WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUL 14 1936

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 21515

1. PLACE OF DEATH
County St. Louis — Registration District No. 791 — File No.
Township — Primary Registration District No. 1003 — Registered No. 5758
City — (No. Jewish Hospital St. Ward)

2. FULL NAME James Chiapello
(a) Residence, No. 5958 Easton Ave. St., 6 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Madelina Chiapello
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug 19, 1863
7. AGE: YEARS 72 — MONTHS 9 — DAYS 11 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Concrete Contractor
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

FATHER
13. NAME: Don't know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

MOTHER
15. MAIDEN NAME: Don't know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

17. INFORMANT (ADDRESS): Mr. John A. Bollato, 6134 Louisiana Ave.
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Calvary Cemetery DATE: June 2, 1936
19. UNDERTAKER (ADDRESS): Geo. L. Pleitsch Inc., 5966 Easton Ave.
20. FILED JUN 1 1936 — J. Bredeck, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 5/30/36, 19

22. I HEREBY CERTIFY, That I attended deceased from May 29th, 1936, to May 30th, 1936
I last saw him alive on 5/29/36, 19 Death is said to have occurred on the date stated above, at 7A m.
The principal cause of death and related causes of importance were as follows:
Chr. arteriosclerosis; Chr. hypertension; Senility.

Date of onset

131

Other contributory causes of importance:
Cerebral apoplexy, involving the 3rd convolusion rt. cerebrum, causing complete hemaplegia left 5/24/36
Name of operation — Date of
What test confirmed diagnosis? cli. Was there an autopsy? no.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Luke B. Tiernor, M. D.
(Address) 3718 Jennings, Rd.

10M-3-28-35

side. Uremia, uremic coma,
cerebral apoplexy from blood clot.

Under care of Dr. Sol Harris occassionally,
and until May 29th.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 21515

Township St. Louis Primary Registration District No. 1003- Registered No. 5758-

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME James Chiapello-

(a) Residence, No. 5458 Easton St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
m	w	Wid.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.
72	9	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 11/12, 1936 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30, 1936

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Chronic Nephritis

Date of onset

Other contributory causes of importance:

Uremia - Uremic Coma -

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Luke B. Tiernon M. D.

(Address) 3718 Jennings Rd.

SUPPLEMENTAR

131

S-21515