

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.

714 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32469

Do not use this space.

8523

1. PLACE OF DEATH

(a) County

Registration District No.

(b) Township

Primary Registration District No.

(c) City St. Louis

(d) Street No. 1508 Warren St.

(e) Length of residence in city or town where death occurred

30 yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Salvatore Schillizzi

(a) Residence, No.

1508 Warren St.

St.

26

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR

DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

Vita Schillizzi

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

July 28, 1881

7. AGE

YEARS

56

MONTHS

1

DAYS

10

If LESS than 1

day, ... hrs.

or min.

OCCUPATION

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

Laborer

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

Iron Works

10. Date deceased last worked at
this occupation (month and
year) 1934

11. Total time (years)
spent in this
occupation

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

unknown
Italy

FATHER

13. NAME

Castor Schillizzi

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

unknown
Italy

MOTHER

15. MAIDEN NAME

Stella (unknown)

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

Unknown
Italy

17. INFORMANT
(ADDRESS)

Vita Schillizzi
1508 Warren St.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Calvary

DATE

Sept. 11, 1937

19. FUNERAL DIRECTOR
(ADDRESS)

P. Miceli & Son

20. FILE

SEP 10 1937

G. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

9/8 1937

22. I HEREBY CERTIFY, That I attended deceased from

I saw, 1936, to 9/8, 1937

I last saw him alive on 9/8, 1937. Death is said

to have occurred on the date stated above, at 11:45 a.m.

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

chronic myocarditis

Date of onset

7/5/37

Other contributory causes of importance:

carcinoma of rectum

Jan 1935

Name of operation

None

Date of

What test confirmed diagnosis?

Section of rectum

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? No

If so, specify

(Signed) J. P. Belman, M. D.

(Address) 1510. no. 16 St.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Arnold W. Schoene, Licensed Embalmer No. 3864

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Arnold W. Schoene

Licensed Embalmer No. 3864

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)