

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.

REC'D JUL 12 1938

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

20119  
 Do not use this space.

1. PLACE OF DEATH

(a) County.....  
 (b) Township.....  
 (c) City St. Louis

Registration District No. 791  
 Primary Registration District No. 1003  
 (d) Street No. City Hospital

Registered No. 5258

(e) Length of residence in city or town where death occurred  
Cl 7495

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

2. PRINT FULL NAME

James May also known as James Maggio. 000 - 3 016

(a) Residence, No. 3863 Washington 19

(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 Myrtle May

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 9, 1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
45 6 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Clerk.  
 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 Vincenzo Maggio

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

MOTHER 15. MAIDEN NAME Rose Pizzo.

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

17. INFORMANT (ADDRESS) Mrs. Myrtle May, t. 3863 Washington Blvd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE June 11, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James P. Budick 1138 W. 6th St.

20. FILED JUN 9 1938 J.P. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/8/38 19

22. I HEREBY CERTIFY, That I attended deceased from 2/28/38, 19, to 6/8/38, 19.

I last saw him on 6/8/38, 19. Death is said to have occurred on the date stated above, 8.35 a.m.

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

Pulmonary tuberculosis

Date of onset

Other contributory causes of importance: J.B.

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... 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) Dr. Maxwell M. D.

(Address) City Hospital Bldg

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Ernest N. D.

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

*Ernest N. D.*

Licensed Embalmer No. 3915

P. O. Address Haris M.

**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.)**

**If this body is not embalmed, above space should be left blank.**