REC'D FEB 10 1939

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

Do not use this space. 611

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 611

(c) City St. Louis (d) Street No. 4519 West Easton Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME Frank B. Paxhia.

(a) Residence, No. 4519 West Easton Ave. St. 11
(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Married. |

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15, 1881.

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 57 | 7 | 1 | |

OCCUPATION

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

9. Industry or business in which work was done, as 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 Amanual Paxhia.

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

MOTHER

15. MAIDEN NAME Marie Antonia.

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

17. INFORMANT (ADDRESS) Mrs. Catherine Paxhia. 4519 West Easton Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cemetery DATE January 20, 1939

19. FUNERAL DIRECTOR (NAME) Geo. L. Pleitsch Inc.
(ADDRESS) 5966 Easton Ave.

20. FILED JAN 19 1939 J. F. Bridach
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

No Attending Physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/17, 1939

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 1 15/A m.

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

Chronic Nephritis

Date of onset

Other contributory causes of importance:

Arteriosclerosis

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

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

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) Joseph M. Zuckerman

(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

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.

## 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, 3454 David C. Gibson, or by .....

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

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address St Louis

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

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