

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

20159
Do not use this space.

JUL 12 1939

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1. PLACE OF DEATH

(a) County 2 Registration District No. _____
 (b) Township _____ Primary Registration District No. _____ Registered No. 5003
 (c) City St. Louis, (d) Street No. 1942 Gravois 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 570 Foster Dina

(a) Residence, No. 1942 Gravois St. 23 (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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 1, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 Months

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. None
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) St. Louis, Mo.

FATHER
13. NAME Louis Dina
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Albania

MOTHER
15. MAIDEN Mary Litza
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Albania

17. INFORMANT (ADDRESS) Louis Dina
1942 Gravois

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Matthews **DATE** June 2, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. C. Moydell
1926 Allen Ave.

20. FILE JUN 2 1939 J. B. Bueck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/1/39

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:

Sepsis as a result of Sacs Bone

Other contributory causes of importance:
Cause Unknown

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? Yes
 If so, specify _____
 (Signed) Joseph M. Quinn M.D.
 (Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

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.

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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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Benj. C. Duncan*

Licensed Embalmer No. *2272*

P. O. Address *1926 Allen*

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.