

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.

350 AUG 11 1939

781
1008

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 5896

1. PLACE OF DEATH:

- (a) County _____
(b) City or town _____
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Anthony Capriglione

3. (b) If veteran, name war _____

no

3. (c) Social Security No. _____

None

4. Sex male

5. Color or race W

6. (a) Single, widowed, married, divorced _____

was

6. (b) Name of husband or wife _____

Mary

6. (c) Age of husband or wife if alive _____ years

50

7. Birth date of deceased _____

about

52 years

8. AGE:

Years

Months

Days

If less than one day

abt 52

9. Birthplace _____

Italy

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

Labourer

11. Industry or business _____

MOTHER FATHER

12. Name _____

Joseph Capriglione

13. Birthplace _____

Italy

(City, town, or county)

14. Maiden name _____

Saverina Capriglione

15. Birthplace _____

Italy

(City, town, or county)

16. (a) Informant's own signature _____

Mary Capriglione

(b) Address _____

4431 De Touhy

17. (a) _____

July 5 1939

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

St Peter's Church

18. (a) Signature of funeral director _____

Paul C. Calcester

(b) Address _____

5142 Daggert Ave

19. (a) _____

1939

(b) _____

(Registrar's signature) J. F. Budech

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

(c) City or town St Louis

(If outside city or town limits, write "RURAL")

(d) Street No. 4431 De Touhy

(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1939 hour 6:30 minute P M.

21. I hereby certify that I attended the deceased from June 22, 1939, to June 30, 1939, and that I last saw him alive on June 30, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis, acute caused by arterio sclerosis

Duration

3 da

Due to _____

Due to _____

Other conditions: Cerebral Hemorrhage

(Include pregnancy within 5 months of death)

8-10 da.

Major findings: right side

Of operations: 1/2 a

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Walter E. Abell M.D. (M. D. or other)

Address 2253 S. 39th Date signed 2-3-39

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.....

Paul Calcaterra

Licensed Embalmer No. *2376*

P. O. Address.....

5142 Dagget

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.