

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.

REC'D AUG 17 1939

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

791
1003

24020
Do not use this space.

6293

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 1
 (b) Township St. James Primary Registration District No. 1003
 (c) City St. James (d) Street No. St. Johns Hospital Registered No. 6293
 (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

(a) Residence, No. John Montagna 532 St. NR (If nonresident, give city or town and State)
St. Louis
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Montagna
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23 1882
 7. AGE YEARS 56 MONTHS 9 DAYS 23 IF LESS than 1 day,hrs. ormin.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None worked
 9. Industry or business in which work was done, as saw mill, bank, etc. Ill
 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 Angelo Montagna
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy
 MOTHER 15. MAIDEN NAME Naboracum
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Italy
 17. INFORMANT (ADDRESS) Pete Montagna
St. James MO
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Hope DATE July 18-39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Donald Dand G
7720 Michigan Ave
J. F. Budick
Local Registrar.
 20. FILED JUL 17 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16 - 1939
 22. I HEREBY CERTIFY, That I attended deceased from March 31, 1939, to July 16, 1939
 I last saw him alive on July 15, 1939 Death is said to have occurred on the date stated above, at 9 A.M.
 The principal cause of death and related causes of importance were as follows:
Esophageal carcinoma
Perforation into left
main bronchus
 Date of onset Jan. 1939
 Other contributory causes of importance:
Terminal bronchopneumonia
auricular fibrillation with
degenerative heart disease
 Name of operation none 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) Bruce Kenemore M. D.
 (Address) 3720 Washington - St. Louis

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.....

Claver F. Miller

....., Registered Apprentice No. *166*

working under my personal supervision.

Signed

Wilson Collins

Licensed Embalmer No.

3887

P. O. Address

Solomons, Mo

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.