

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34275**
Registrar's No. **8972**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether)
In this community
years, months or days

3. (a) PRINT FULL NAME **Charles J. Cella**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Harriet Cella** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **March 1st 1875**
(Month) (Day) (Year)

8. AGE: Years **65** Months **7** Days **28** If less than one day
hr. min.

9. Birthplace **Chicago Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Southern Real Estate Co.**

11. Industry or business **President of**

12. Name **John G. Cella**

13. Birthplace **Italy**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Italy**
(City, town, or county) (State or foreign country)

16. (a) Informant **Harriet Cella**

(b) Address **7104 Delmar Ave.**

17. (a) **Burial** (b) Date thereof **10-1-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Kriegshauser Mortuaries**

(b) Address **4228 So. Kingshighway Blvd.**

19. (a) **OCT 31 1940** (b) Date received local registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **University City**
(If outside city or town limits, write "RURAL")
(d) Street No. **7104 Delmar Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **29th**
year **1940** hour **8:05** minute **P.M.** M.

21. I hereby certify that I attended the deceased from **Aug 20 1934** to **Oct 29 1940**
that I last saw him alive on **Oct 29 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebrovascular disease

Due to **Coronary disease**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?

(Specify type of place) (e) Means of injury

23. Signature **F. R. Finnigan** (M. D. or other)
Address **Humboldt St.** Date signed **Oct 29 1940**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

7416585

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

Clarence A. McHenry

Licensed Embalmer No.

3024

P. O. Address

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

If this body is not embalmed, fact should be so stated above.