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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **20391**  
Registrar's No. **5203**

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**City Hospital # 10**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **100**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL") **1712**  
(d) Street No. **5012a Maple Ave.**  
(If rural, give location) **F**  
(e) If foreign born, how long in U. S. A? **0** years.

3. (a) PRINT FULL NAME **Paulucci, William**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife **Lillian** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **July 13 1889**  
(Month) (Day) (Year)

8. AGE: Years **71** Months **11** Days **8** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

12. Name **Joseph Paulucci**

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

14. Maiden name **Margaret**

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

16. (a) Informant **Mrs. Roy Martin**  
(b) Address **Kenton, Ohio**

17. (a) **Removal** (b) Date thereof **6/24/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Kenton, Ohio.**

18. (a) Signature of funeral director **Albert H. Koppe**  
(b) Address **4700 Washington Ave.**

19. (a) **JUN 24 1941** (b) **J. Thredock**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28** year **1941** hour **7:10** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **May 2, 1941** to **June 21, 1941**; that I last saw him alive on **June 21, 1941** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis 1 1/2 hrs**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations **None**

Of autopsy **none done**

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 **J. Thredock** (M. D. or other) \_\_\_\_\_  
Address **City Hospital** Date signed **6/22/41**

PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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 *R. W. Wilkinson*

Licensed Embalmer No. 3575

P. O. Address \_\_\_\_\_

**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.**