

Registration District No. 791 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 4 Days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. #311 McPherson Ave
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1
year 1941 hour 1:00 minute P. M.

21. I hereby certify that I attended the deceased from July
29, 1941 to August 1, 1941
that I last saw him alive on August 1, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chronic Alcoholism
Alcohol Tremens
Due to.....
Due to.....
Other conditions
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged statisti-
cally.

3. (a) PRINT FULL NAME William Di Matteo

3. (b) If veteran, name war..... 3. (c) Social Security No. 098-12-9171

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

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

7. Birth date of deceased. Jan 24th 1894
(Month) (Day) (Year)

8. AGE: Years 47 Months 6 Days 7 If less than one day
hr. min.

9. Birthplace New York New York /
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business.....

12. Name William Di Matteo

13. Birthplace New York /
(City, town, or county) (State or foreign country)

14. Maiden name Alice Kennedy

15. Birthplace New York /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Carmen Stintone

(b) Address 1062 Stell Place Bronx N. Y.

17. (a) Removal (b) Date thereof 8/5/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Calvary Cem Bronx N. Y.

18. (a) Signature of funeral director. Strook - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) AUG - 3 1941 (b) J. F. Brudak
(Date received local registrar) (Registrar's signature)

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) (Means of injury)

23. Signature [Signature] (M. D. or other) 8/1/41
Address 1516 Lafayette Ave., Date signed

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

00
117
9

000
17
194

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.....

Frank H. Shurt

Licensed Embalmer No. 2265

P. O. Address 4600 North Bridge

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, fact should be so stated above.