

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

7464

1. PLACE OF DEATH:

318

(a) County _____
(b) City or town _____
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ 20
years, months or days

2. USUAL RESIDENCE OF DECEASED:

1003

(a) State Mo (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5343 G Wilson
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dominic Prestangelo

3. (b) If veteran, name war no 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Margarete Balloni 6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased: June (Month) 6 (Day) 1922 (Year)

8. AGE: Years 20 Months 2 Days 29 If less than one day hr. _____ min. _____

9. Birthplace: St Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation A & P. Co.

11. Industry or business _____

12. Name Sam Prestangelo

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

14. Maiden name Domemica Ferrante

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

16. (a) Informant Mrs Margaret Balloni

(b) Address 5343 G Wilson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 1942 (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter Paul Cemetery

18. (a) Signature of funeral director Wm C Culbertson

(b) Address 514 1/2 Ave

19. (a) SEP 7 1942 (Date received local registrar) (b) J. G. Bullock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5th year 1942 hour 6:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death: hemorrhage from severance of left external iliac artery by bullet
Duration _____
Died at the hands of Dr. Salvatore Delia at 5343 Wilson ave about 6:30 pm 9/5/42

(Other conditions. Include pregnancy within 3 months of death)

22. Major findings: _____ Of operations: _____

Of autopsy: _____

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

(a) homicide (Specify) _____

(b) Date of occurrence 9/5/42

(c) Where did injury occur? St. Louis Mo (City or town) (County) (State)

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

(Specify type of place)

(e) Means of injury _____

23. Signature Thomas J. Callahan (or other)

Address Deputy, Darnest Date signed 9/9/42

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 C. Calaterra

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, fact should be so stated above.