

Registration District No.

Primary Registration District No. **1003**

318

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:
Faith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Weeks**
(Specify whether
In this community..... **37 years**
years, months or days)

3. (a) PRINT FULL NAME **Giuseppe Mangiapanello**

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 **Married**

6. (b) Name of husband or wife **Francesca** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **August 15 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 8 28 hr. min.

9. Birthplace **Castelvetro Italy 5**
(City, town, or county) (State or foreign country)

10. Usual occupation **Labor**

11. Industry or business.....

MOTHER FATHER { 12. Name **Giovanni Mangiapanello**
13. Birthplace **Castelvetro Italy 5**
(City, town, or county) (State or foreign country)
14. Maiden name **Antonietta Porcella**
15. Birthplace **Castelvetro Italy 5**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Mangiapanello**
(b) Address **2508 Cass Ave.**

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

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

18. (a) Signature of funeral director **P. Michi - Son**

(b) Address **1150 N. Kingshighway**

19. (a) **MAY 15 1943** (b) **J. F. Bredak**
(Date received local registrar) (Registrar's signature)

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. **2508 Cass Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country..... **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5/13/43** day
year..... hour **6:18 PM** minute..... M.

21. I hereby certify that I attended the deceased from **4/23/43**
19..... to **5/13**, 19.....
that I last saw him alive on **May 13 1943**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Hypostatic Cardia -
Vascular disease

Due to.....
108

Other conditions.....
(Include pregnancy within 3 months of date of death)
1) Cerv. embolism
2) At. pulm. nephritis

Major findings: **2) L. colar pneumonia**
Of operations.....

Of autopsy **alone**

Duration
3
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 **A. Signorilli** (M. D. or other) **MD**
Address **2801 N. Taylor Ave.** Date signed **5/14/43**

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

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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, fact should be so stated above.