

S. No. 2  
OM-2-43  
5-17-39  
X3363

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18938  
State File No. \_\_\_\_\_  
Registrar's No. 1325

Registration District No. 217

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Veterans Administration Facility  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm. May 29, 1943  
(Specify whether years, months or days)

In this community unknown.

3. (a) PRINT FULL NAME August J. Chilese

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 492-03-4913

4. Sex male Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Eleanora

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased August 24, 1896  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>9</u>	<u>9</u>	hr. min.

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

10. Usual occupation Laborer

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

12. Name Antonio Chilese

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

14. Maiden name Lena Pozza

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

16. (a) Informant M. Schuller

(b) Address Clinical Clerk, VAF, Jeff. Bks., No.

17. (a) ~~(Burial, cremation, etc.)~~ (b) Date thereof 6-2-43  
(Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter's Church

18. (a) Signature of funeral director Sam @ Calabrese

(b) Address 5142 Daggert Ave

19. (a) W. E. [unclear] (b) [unclear]  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2127 Marconi Street  
(If rural, give location)

(e) Citizen of foreign country? - (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd. year 1943 hour 10:45 minute P. M.

21. I hereby certify that I attended the deceased from May 29, 19 43 to June 3, 19 43 that I last saw him alive on June 3, 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death EMPHYEMA, RIGHT PLEURAL CAVITY. Duration Abt. 3 weeks

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

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

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

Major findings: Thoracentesis, right, 6/3/43. PHYSICIAN

Of operations \_\_\_\_\_ Underline the cause to which death should be charged statistically.

Of autopsy No autopsy.

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

(a) Accident, suicide, or homicide (specify) NO

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)

23. Signature L. M. SOCHRAN, M.D. (M. D. or other) \_\_\_\_\_  
Address Chief Medical Officer. Date signed 6/4/43.

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.....

*Saul Calcaterra*

Licensed Embalmer No. 2376

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, fact should be so stated above.**