

S. No. 2
OM-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26440

State File No. _____

ED AUG 23 1943

Registration District No. 318

Primary Registration District No. 1002

Registrar's No. 7314

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1548 GIESKING LANE /
(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)

3. (a) PRINT FULL NAME MARY A. ANGELO

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married. Divorced WIDOW

6. (b) Name of husband or wife. JOHN A. ANGELO 6. (c) Age of husband or wife if alive. _____ years

7. Birth date of deceased. MAY 7, 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 6 If less than one day hr. min.

9. Birthplace. ST. LOUIS MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation. AT HOME

11. Industry or business.

12. Name. JOHN GANNON

13. Birthplace. IRELAND 4
(City, town, or county) (State or foreign country)

14. Maiden name. MARY LUBEY

15. Birthplace. IRELAND 4
(City, town, or county) (State or foreign country)

16. (a) Informant. JAMES T. ANGELO

(b) Address. 1548 GIESKING LANE

17. (a) BURIAL (b) Date thereof. 8-16-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. CALVARY CEMETERY

18. (a) Signature of funeral director. Arthur J. Donnelly

(b) Address. 3840 Lindell Blvd.

19. (a) AUG 14 1943 (Date received local registrar) J. F. Deede (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. LOUIS
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1548 GIESKING LANE
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13 year 1943 hour 2:00 P. M. minute 00

21. I hereby certify that I attended the deceased from Aug 13 to Aug 13 1943 that I last saw her alive on Aug 12 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis

Due to: Embolism of gall bladder arteries
Due to: German measles
Stone in ampulla

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

Major findings: Of operations

Of autopsy: ja

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) _____ (M.D. or other)

3. Signature: M. J. Deede (M.D. or other) Address: 506 Olive Date signed: 8/13/43

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

MOTHER FATHER

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 William Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.