

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 9995

FILED NOV 29 1943

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County xx 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:
DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
In this community 11 days
years, months or days

3. (a) PRINT FULL NAME JOSEPH CASTELLI

3. (b) If veteran, name war no
3. (c) Social Security No. 343-09-8815

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

6. (b) Name of husband or wife Amelia Castelli
6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Dec 27th-1900
(Month) (Day) (Year)

8. AGE: Years 42 Months 10 Days 28
If less than one day hr. _____ min.

9. Birthplace South America
(City, town, or county) (State or foreign country)

10. Usual occupation Sta. Fireman

11. Industry or business Laclede Gas Co.

12. Name Paul Castelli

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

14. Maiden name Catherine Reano

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

16. (a) Informant Amelia Castelli
(b) Address Collinsville, Ills.,

17. (a) burial (b) Date thereof Nov 17/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Collinsville Ills.

18. (a) Signature of funeral director Geo. M. Schroppel
(b) Address Collinsville, Ills.

19. (a) NOV 15 1943 (b) J. F. Breda
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ills. (b) County Madison
(c) City or town Collinsville
(If outside city or town limits, write "RURAL")
(d) Street No. 107 Amanda Ave
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14th
year 1943 hour 1 minute 35 P. M.

21. I hereby certify that I attended the deceased from Oct 25, 1943 to Nov 14, 1943
that I last saw him alive on Nov 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma left testis
Due to Metastasis to testicle

Due to Metastasis to testicle

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

Major findings: Carcinoma of left testis
Of autopsy _____

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 R. C. ... (M. D. or other)
Address 117 N. Grant Date signed 11/17/43

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

MOTHER FATHER

DEC 23 1944

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, ~~XX~~By.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed L. M. Schaeffer

Licensed Embalmer No. 1598

P. O. Address Collinsville, Ills.

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.