

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
(Specify whether  
In this community 62 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3154<sup>a</sup> School Str  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph ~~Bovior~~ Berinile

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 498-07-4950

4. Sex M 5. Color or race 2601 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Rosie 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased Aug 7<sup>th</sup> 1862  
(Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 15 If less than one day hr. min.

9. Birthplace Belleville Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

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

12. Name Louis Berinile

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

14. Maiden name Marie Coleman

15. Birthplace unk 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Rosie Berinile

(b) Address 3154<sup>a</sup> School Street

17. (a) Burial (b) Date thereof 7-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director J. R. Randle

(b) Address 3133 Billy Ave

19. (a) JUL 25 1944 (b) J. F. Prebeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22, year 1944 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 9, 1944, to July 22, 1944;  
that I last saw him alive on July 22, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Cardio-vascular disease

Duration Unknown

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

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

(c) Accident, suicide, or homicide (specify) \_\_\_\_\_

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

(c) Where did injury occur? \_\_\_\_\_ (City or town) (Country) (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 Alura Mason (M. D. or other) \_\_\_\_\_

Address 2001 Whittier Date signed 7/27/44

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 *J. J. Thorton*

Licensed Embalmer No. *2698*

P. O. Address *2769 Chouteau*

**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.**

*6/19/21*