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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 16 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **860**
Registrar's No. **30**

Registration District No. _____ Primary Registration District No. _____

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:
Park Lane Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks.
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Antonino Valenti.

3. (b) If veteran, name war None

3. (c) Social Security No. 499-26-0530

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 10, 1891
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>7</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Shoe Worker

11. Industry or business Millius Shoe Co.

12. Name Nick Valenti.

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

14. Maiden name Maria Nicastri.

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

16. (a) Informant Nick Valenti

(b) Address 1601 N. 17th St.

17. (a) Burial. (b) Date thereof Jan. 5, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bernice McHale
(b) Address 1431 Union Plv.

19. (a) JAN 3 1948 (b) J. F. Bredesch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____

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

(d) Street No. 1601 N 17th
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2
year 1948 hour 8 minute 20 AM.

21. I hereby certify that I attended the deceased from 12
15 1948 to 1 - 2 1948
that I last saw h. (M.) alive on 1-2- 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Staphylococcus aureus
ca + metastatic pneumonia
in 2nd pair of body
(head + arm)

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

Duration _____

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? _____

23. Signature J. F. Bredesch (M. D. or other) _____
Address 4930 S. Lindbergh Date signed 1-4-48

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 *James M. Keenan*

Licensed Embalmer No. *5915*

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.