

FILED MAR 3 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1568

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: Firmin Deslodge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days) 0

3. (a) PRINT FULL NAME William Salvatore Mantia

3. (b) If veteran, name war None, 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Mantia 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 25, 1884
(Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days 21 If less than one day hr. min.

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

10. Usual occupation Wholesale Fruit Merchant

11. Industry or business _____

MOTHER FATHER { 12. Name Anthony Mantia

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

14. Maiden name Agata Cairo

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

16. (a) Informant Anna Mantia

(b) Address 3900 Parker Ave.

17. (a) Burial. (b) Date thereof Feb. 20, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Daniel Michalek

(b) Address 1431 Union Blvd.

19. (a) FEB 17 1945 (b) J. F. Busch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3900 Parker Ave.
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15
year 1945 hour 3.50 minute a. M.

21. I hereby certify that I attended the deceased from 2-13, 1945 to 2-15, 1945

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic Leukemia, acute

Due to _____

Due to _____

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

Major findings: Of operations not done

Of autopsy not done

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) Means of injury _____

23. Signature E. Lee Shroder (M.D. or other) _____

Address 3720 Washington Date signed 2/15/45

Duration

3 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 

Licensed Embalmer No. 2915

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, above space should be left blank.