S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 11 1945

Registration District No. 3717

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10617

Primary Registration District No. 6076

Registrar's No. 867

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

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. 1332 Bayard (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3. (a) PRINT FULL NAME: Peter A. Gragnani
3. (b) If veteran, name war: World War I
3. (c) Social Security No.: 489-07-7021
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Nellie
6. (c) Age of husband or wife if alive: 66 years
7. Birth date of deceased: April (Month) 2 (Day) 1888 (Year)
8. AGE: Years 57 Months — Days 4 If less than one day hr. min.
9. Birthplace: Milwaukee (City, town, or county) Wisconsin (State or foreign country)
10. Usual occupation: Hunter
11. Industry or business: St. Louis Post-Dispatch
MOTHER FATHER
12. Name: Alessandro Gragnani
13. Birthplace: Italy (City, town, or county) (State or foreign country)
14. Maiden name: Celestina Bernardini
15. Birthplace: Italy (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Nellie Gragnani
(b) Address: 1332 Bayard
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation: National Cem. Jefferson Barracks
18. (a) Signature of funeral director: Chas. F. Stuart
(b) Address: 1225 Union Blvd.
19. (a) APR 9 1945 (Date received local registrar) (b) E. C. McGowan, M.D. (Registrar's signature) By

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6 year 1945 hour 12:45 minute A. M.
21. I hereby certify that I attended the deceased from April 2, 1945, to April 5, 1945, that I last saw him alive on April 5, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension,	8 yrs.
Due to 8361	
Other conditions Arteriosclerosis (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:
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Joseph R. Mack (M. D. or other) M.D.
Address: 6934 Kingsbury Date signed 4/6/45

(Licensed Embalmer's Statement on Reverse Side)

707

-239
-11-45

APR 17 1945

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: John Ogonoski

Licensed Embalmer No. 2398

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.