

FILED MAY 12 1945

818

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 3820

1. PLACE OF DEATH:

(a) County _____
(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:
City Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 Days (Specify whether
In this community 36 years
years, months or days)

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. 1007 Cole St.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1945 hour 11:30 minute _____ A.M.
21. I hereby certify that I attended the deceased from 4/25/45
to Apr 29 1945
that I last saw him alive on Apr 29 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Regenerative heart disease Duration _____

Due to _____
Due to _____

Other conditions Senility
(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) (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 Car
23. Signature Dr. Max Wald (M. D. or other) _____
Address 5800 Arsenal Date signed 4-29-45

3. (a) PRINT FULL NAME Angelo, Spia

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 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 September 22 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Porter

11. Industry or business _____

12. Name Giovanne Spia

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

14. Maiden name Esabeth Cappadonna

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

16. (a) Informant Tommaso Ghem
(b) Address 5700 Arsenal

17. (a) Burial (b) Date thereof May-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director P. Michi-Sons

(b) Address 1150 N. Kingshighway Blvd.

19. (a) APR 30 1945 (b) J. F. Budek
(Date received local registrar) (Registrar's signature)

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

100
17
9

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo

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.