#51506

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39738

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10896

v. 5-17-39
I X36671

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 33 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. 2428 N. Spring
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Gaspare San Paolo

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 March (Month) 15 (Day) 1912 (Year)

8. AGE:

Years	Months	Days	If less than one day
33	8	27	hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Carlo San Paolo
13. Birthplace Carini (City, town, or county) Italy (State or foreign country)

MOTHER
14. Maiden name Gaetana Randazzo
15. Birthplace Carini (City, town, or county) Italy (State or foreign country)

16. (a) Informant Carlo San Paolo
(b) Address 2428 N. Spring Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director P. Miceli-Sons
(b) Address 1150 N. Kingshighway Blvd.

19. (a) DEC 14 1945 (Date received local registrar) (b) J F Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 12th year 1945 hour 8:45 minute A M.

21. I hereby certify that I attended the deceased from 12/10/45, 19, to 12/12/45, 19; that I last saw him alive on 12/12/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Bacillary Dysentery

Due to

Due to

Other conditions Undiagnosed CNS lesion present for 20 yrs which may be diagnosed on subsequent brain + spinal cord tissue study
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy multiple abscesses + ulcers of entire colon

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W H Hamilton 1515 Lafayette (M.D. or other) 12/12/45 M.D.

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 V. E. Morris

Licensed Embalmer No. 3360

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.