

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18740**
Registrar's No. **5267**

FILED JUN 5 1947
318

Registration District No. _____ Primary Registration District No. **1003**

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. John's 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 _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **96**

(c) City or town **Lemay**
(If outside city or town limits, write "RURAL")

(d) Street No. **435 Kingston Dr.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **ANTHONY DeBIASI**

3. (b) If veteran, name war **None**

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Angelina**

6. (c) Age of husband or wife if alive **Abt. 40** years

7. Birth date of deceased **Sep't. 6th 1900**
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| 46 | 8 | 20 | hr. _____ min. _____ |

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

10. Usual occupation **Chief Engineer**

11. Industry or business **McCabe Powers Co.**

12. Name **Frank DeBiasi**

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

14. Maiden name **Angelina Unknown**

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

16. (a) Informant **Angelina DeBiasi**

(b) Address **435 Kingston Dr.**

17. (a) **Burial** (b) Date thereof **5 29 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Resurrection Cem**

18. (a) Signature of funeral director **Kriegshauser Und. Co.**

(b) Address **4228 So. Kingshighway Bl.**

19. (a) **MAY 27 1947** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **26**
year **1947** hour **12:45** minute **A.M.**

21. I hereby certify that I attended the deceased from **June 1945**
to April 1947, to _____ 19____;
that I last saw him alive on **5/26**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemiplegia
(Right side)

Due to _____

Due to _____

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature **J. Granoto M.D.** (M. D. or other) **0**
Address **5521 S. Boling** Date signed **5/27/47**

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

FEB 25 1948

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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 Richard W. Stoverand

Licensed Embalmer No. 4007

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.