

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36139**
Registrar's No. **9643**

FILED NOV 3 1947

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

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4547 St. Louis Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **44 years** years, months or days)

3. (a) PRINT FULL NAME **pasquale palmisano**
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 **Widowed**
6. (b) Name of husband or wife **Rosa** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May 10 1887**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 5 5 hr. min.

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

10. Usual occupation **Labor**

11. Industry or business _____

MOTHER FATHER
12. Name **Salvatore palmisano**
13. Birthplace **Italy**
(City, town, or county) (State or foreign country)
14. Maiden name **Marie**
15. Birthplace **Italy**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joe Bohana**
(b) Address **4547 St. Louis Ave.**

17. (a) **Burial** (b) Date thereof **Oct. 18-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **P. Miceli & sons**
(b) Address **1150 N. Kingshighway**

19. (a) **OCT 17 1947** (b) **J. Bredsch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4547 St. Louis Ave**
(If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country **Italy**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **15** day **Oct.**
year **1947** hour _____ minute **6:20** P.M.
21. I hereby certify that I attended the deceased from **6/6**, 19**47** to **10/15**, 19**47**
and that death occurred on the date and hour stated above.
that I last saw him alive on **10/15**, 19**47**

Immediate cause of death **Carcinoma sigmoid** Duration **4 mos.**
Due to _____
Due to _____
Other conditions **none**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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?
While at work (Specify type of place) (e) Means of injury _____
23. Signature **Jo. P. Berman** (M. D. or other) _____
Address **1225 - 70 Grand** Date signed **10-16-47**

over

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..... *Anthony J. Mudi*.....
Licensed Embalmer No. *4297*.....
P. O. Address..... *St. Louis*.....

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.