No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43868

FILED DEC 22 1947

Registration District No. ..... Primary Registration District No. 6076 Registrar's No. 2509

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 826 days.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County ~~St Louis~~ 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4727 Page 9
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 1
If yes, name country .....

3. (a) PRINT FULL NAME Natale Stefani

3. (b) If veteran, name war — 3. (c) Social Security No. 492-20-8220

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Ellen 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Dec (Month) 25 (Day) 1884 (Year)

8. AGE: Years 62 Months 11 Days 1 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Italy (State or foreign country) 5

10. Usual occupation ~~Laborer~~ Housewife

11. Industry or business .....

FATHER
12. Name John Stefani 5
13. Birthplace Italy (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ellen Seganfredo 5
15. Birthplace Italy (City, town, or county) (State or foreign country)

16. (a) Informant Hospital records
(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/47 (Month, Day, Year)
(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Sullivan Funeral Dir
(b) Address 7849 No Euclid

19. (a) 12-4-47 (Date received local registrar) (b) Cecil A. Shaw (Registrar's signature) MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25
year 1947 hour 1 minute 03 P M.

21. I hereby certify that I attended the deceased from August 22 1944, to Sept. 26, 1947
that I last saw him alive on Sept. 26, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary tuberculosis	17 yrs (?)
Due to	
Due to 13 b	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Same	

PHYSICIAN
Underline the cause of 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 Elmer W. Gebhardt (M. D. ~~or other~~)
Address Robert Koch Hosp. Date signed 12/2/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

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 Robert L. Pinkman

Licensed Embalmer No. 3523

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.