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FEDERAL BUREAU OF VITAL STATISTICS  
MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED JUL 23 1948

State File No. \_\_\_\_\_

Registration District No. **310**

Primary Registration District No. **1003**

Registrar's No. **6319**

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: St. John 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 \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 612 So. Boyle  
 (If rural, give location)  
 (e) Citizen of foreign country? (18) (Yes or No) \_\_\_\_\_  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES BELGERI  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. 489-01-3952

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 15  
 year 1948 hour 2 minute A M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Rose Colombo  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 17 1893  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 26, 1948 to July 15, 1948 that I last saw him alive on July 15, 1948 and that death occurred on the date and hour stated above.

8. AGE: Years 55 Months 7 Days 27  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Carcinoma of mediastinum Duration 1 year  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Tumor involving mediastinum & Right Lung obstructing superior vena cava.  
 Of operations \_\_\_\_\_  
 Of autopsy (Some)

9. Birthplace Switzerland  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation merchant

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name Paul Belgeri  
 13. Birthplace Switzerland  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Rose Rongoni  
 15. Birthplace Switzerland  
 (City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Rose Belgeri  
 (b) Address 612 So. Boyle  
 17. (a) Burial (b) Date thereof July 17 1948  
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

18. (a) Signature of funeral director Paul C. Calcuttano  
 (b) Address 5142 N. 2nd Ave  
 19. (a) Jul 16 1948 (Date received for registration)  
J.F. Braddock (Registrar's signature)

23. Signature John J. Hennelly (M. D. or other) MD  
 Address 4203 Chippen Date signed 7/16/48

JUL 16 1948

(Licensed Embalmer's Statement on Reverse Side)

JOHN J HENNELLY

MAKE A PERMANENT RECORD

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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..... *Paul C. Calcaterra* .....

Licensed Embalmer No. *2376* .....

P. O. Address..... *5142 Dagge* .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

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3880

Registration District No. 318

Primary Registration District No. 1003

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: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME James Belgeri

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Nov 17  
(Month) (Day) (Year)

8. AGE: Years 55 Months 7 Days \_\_\_\_\_ (if less than one day) hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) Switzerland (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-16-48 (b) J F Bredsch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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:

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

S-241097