

FILED NOV 1 1948 42
Registration District No. **42**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Mercy Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
In this community **60 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **2807 S. 24th**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Pasquale DeSalvo**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **unknown**

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mary DeSalvo** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **March 23, 1860**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	88	6	23	hr. min.

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

10. Usual occupation **retired**
11. Industry or business **Quaker Oats Company**

12. Name **unknown**
13. Birthplace **Italy**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **Italy**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Irene DeSalvo**
(b) Address **2114 S. 15**
17. (a) **Burial** (b) Date thereof **10/23/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Olivet**

18. (a) Signature of funeral director **Hester - Bowman**
(b) Address **319 S. 10th, St. Joseph, Mo**
19. (a) **10-25-48** (b) **E. B. Jenkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **21**
year **1948** hour **7** minute **45** P.M.

I hereby certify that I attended the deceased from **Oct 20** 19**48** to **Oct 21** 19**48**
that I last saw him alive on **Oct 21** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**
Chronic myocarditis
Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **937**
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) (c) Mans of injury **2**
23. Signature **H. B. Raymond** (M.D. or other)
Address **209-210 Parkland Bldg** Date signed **10/22/48**
St Joseph, Mo.

Duration

sudden

PHYSICIAN

Underline the cause of which death should be charged statistically.

Dr. Raymond Smith
Kirkpatrick, Ar

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 William Galling
Licensed Embalmer No. 4535
P. O. Address 319 S. 11th St. Joplin, Mo.

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.