

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17961**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3669** Registrar's No. **890**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 96	
b. CITY OR TOWN Rich Hts Mo c. LENGTH OF STAY (in this place) 1		c. CITY OR TOWN Rich Hts Mo 0 18 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7708 Oakland Ave		d. STREET ADDRESS (If rural, give location) 7708 Oakland Ave 0	
3. NAME OF DECEASED a. (First) JOSEPH b. (Middle) M c. (Last) SILISTRIA			4. DATE OF DEATH (Month) (Day) (Year) April 4 1949
5. SEX MC	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar 11 - 1889
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 24 Days _____ Hours _____ Mins _____	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair	11. BIRTHPLACE (State or foreign country) Sicily
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Jennie Silistria
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Michael Silistria ADDRESS 7708 Oakland Ave
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause unknown ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 7950 200	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Thurid Lemmings MD		23b. ADDRESS St. Louis County Health Dept.	
23c. DATE SIGNED 4/6/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE April 7 - 1949	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Louis City Mo	
DATE REC'D BY LOCAL REG. 4/6/49		REGISTRAR'S SIGNATURE Thurid Lemmings MD	
FUNERAL DIRECTOR'S SIGNATURE Walter Boyce		ADDRESS 6536 Clayton Rd.	

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

96
8
3

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Clement McNeary

Licensed Embalmer No. 3732

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.