

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24848
6802

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>ST. LOUIS</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>ST. LOUIS</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>5135 WILSON</i>		d. STREET ADDRESS (If rural, give location) <i>13 5135 WILSON</i>	

3. NAME OF DECEASED (Type or Print)	a. (First) <i>JOHN</i>	b. (Middle) <i>GUIDICI</i>	c. (Last) <i>GUIDICI</i>	4. DATE OF DEATH (Month) (Day) (Year)
				<i>Aug. 2 1949</i>

5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>July 21, 1878</i>	9. AGE (In years last birthday) <i>71</i>	10. UNDER 1 YEAR Months	11. UNDER 1 HR. Hours	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>not known</i>	13b. MOTHER'S MAIDEN NAME <i>Josephine</i>	14. NAME OF HUSBAND OR WIFE <i>Antonina Guidici</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>490-01-5795</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Charles Guidici</i>	ADDRESS <i>5135 Wilson</i>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>years</i>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral thrombosis</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>B324</i>
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22. I hereby certify that I attended the deceased from *Aug 9, 1949*, to *Aug 2, 1949*, that I last saw the deceased alive on *Aug 2, 1949*, and that death occurred at *11:30 P.M.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Charles Norton, M.D.</i>	23b. ADDRESS <i>5147 Daggelore</i>	23c. DATE SIGNED <i>9-4-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>Aug. 6 1949</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Resurrection</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
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DATE REC'D BY LOCAL REG. <i>AUG 5 1949</i>	REGISTRAR'S SIGNATURE <i>J B Saxator</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Paul C. Calcaterra</i>	ADDRESS <i>5142 Daggelore</i>
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WRITES 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Paul C. Calcesteria

Licensed Embalmer No. 5142 Dargel

P. O. Address 2376

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.