

FILED SEP 12 1949  
#98739

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28358

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7681

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY <i>Ball</i>	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.	c. LENGTH OF STAY (in this place) 6 Weeks	c. CITY (If outside corporate limits, write RURAL and give township). Saint Louis <i>17</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 10-4522 Labadie Avenue, <i>10</i>	

3. NAME OF DECEASED (Type or Print)	a. (First) DOMINICK	b. (Middle) MONTELEONE	c. (Last) MONTELEONE	4. DATE OF DEATH (Month) (Day) (Year) Sept. 2nd, 1949
----------------------------------------	---------------------	------------------------	----------------------	-------------------------------------------------------------

5. SEX Male <i>O</i>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 4th, 1879	9. AGE (In years last birthday) 70	# UNDER 1 YEAR Months 5 Days 28	# UNDER 24 HRS. Hours Min.
-------------------------	---------------------------	-------------------------------------------------------------------	-------------------------------------	---------------------------------------	------------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker	10b. KIND OF BUSINESS OR INDUSTRY Milius Shoe Co.	11. BIRTHPLACE (State or foreign country) Scicily <i>8</i>	12. CITIZEN OF WHAT COUNTRY? USA
----------------------------------------------------------------------------------------------------------	------------------------------------------------------	---------------------------------------------------------------	-------------------------------------

13a. FATHER'S NAME Bernardo Monteleone	13b. MOTHER'S MAIDEN NAME Vingenta Garadi	14. NAME OF HUSBAND OR WIFE Agnes Monteleone nee Rocco
-------------------------------------------	----------------------------------------------	-----------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Agnes Monteleone, 4522 Labadie Avenue	ADDRESS 4522 Labadie Avenue
-------------------------------------------------------------------------------------------------------------	-------------------------	----------------------------------------------------------------------------	--------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.  DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Psychosis cerebral arteriosclerosis</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	18. ABTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <i>11-2-1</i>
------------------------------------------	------------------------------------------------------------------------------------------	------------------------------------------------------------------

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?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 9/2/49, 19\_\_\_\_, that I last saw the deceased alive on 9/2/49, 19\_\_\_\_, and that death occurred at 4:40 AM., from the causes and on the date stated above.

23a. SIGNATURE <i>Gloria Anne Taylor MD</i>	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 9/2/49
------------------------------------------------	-------------------	--------------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/6/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) Saint Louis, Missouri
-----------------------------------------------------	---------------------	--------------------------------------------------------	------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. SEP 6 1949	REGISTRAR'S SIGNATURE <i>J. B. Santos</i>	25. FUNERAL DIRECTOR'S SIGNATURE Calvin F. Feutz, 4828 Natural Bridge Blvd.	ADDRESS
----------------------------------------	----------------------------------------------	--------------------------------------------------------------------------------	---------

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

81

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 John A. Meinar

Licensed Embalmer No. 4186

P. O. Address St. Louis, 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.