

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42742

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 40643

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1330 January Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital			

3. NAME OF DECEASED a. (First) Joseph		b. (Middle)		c. (Last) Maltagliati		4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 16, 1880	
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days		IF UNDER 12 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) Italy	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Phillip Maltagliati		13b. MOTHER'S MAIDEN NAME Maria Unknown		14. NAME OF HUSBAND OR WIFE Chiara	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Chiara Maltagliati, 1330 January	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

18. CAUSE OF DEATH		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Fracture of skull; Subdural hemorrhage			
II. OTHER SIGNIFICANT CONDITIONS		and later run over by automobile driven by Lorraine H. Cooper (cal)			
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
Morbidity conditions, if any, giving rise to the above cause (a), stating the underlying cause last.		DUE TO			

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) Dec 9 49 5:28 p.m.		21e. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK []		21f. HOW DID INJURY OCCUR? Hit	

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 5:28 P. m., from the causes and on the date stated above. 25

23a. SIGNATURE Joseph M. [Signature] (Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 12/12/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-13-49		24c. NAME OF CEMETERY OR CREMATORY Resurrection	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.					

DATE REC'D BY LOCAL REG. DEC 12 1949		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paul C. Calcaterra, 5140 Daggett	
--------------------------------------	--	------------------------------------	--	---	--

WRITE 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 *Robert J. Murray*

Licensed Embalmer No. *3749*

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.