

FILED JUL 22 1950.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25172

State File No.

6073

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). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis.		c. LENGTH OF STAY (In this place) 1 Week	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo Baptiste Hospital		c. CITY (If outside corporate limits, write RURAL and give township). OR TOWN St. Louis 2069	
d. STREET ADDRESS 5878 Theodosia Ave. 0			
3. NAME OF DECEASED (Type or Print) a. (First) Nunzio b. (Middle) Ponte c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 14, 1950
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1	8. DATE OF BIRTH March 25, 1883
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months 3 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? 5	
13a. FATHER'S NAME Michael Ponte		13b. MOTHER'S MAIDEN NAME Vincenza Gisi	
14. NAME OF HUSBAND OR WIFE Carlotta Ponte			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 499-28-5296	
17. INFORMANT'S SIGNATURE OR NAME Michael E. Ponte		ADDRESS Theodosia	
18. DATE OF DEATH Enter only one cause per line for (a), (b), and (c)			
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intussusception of Sigmoid and Palyp of Sigmoid DUE TO (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 6-9-50		19b. MAJOR FINDINGS OF OPERATION Intussusception of Sigmoid	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 570.0			
22. I hereby certify that I attended the deceased from 7-7-50, 19___, to 2-14-50, 19___, that I last saw the deceased alive on 2-13-50, 19___, and that death occurred at 4:35 a.m., from the causes and on the date stated above.			
23a. SIGNATURE 0 (Degree or title)		23b. ADDRESS 45 Central, Clayton, Mo.	
23c. DATE SIGNED 7-14-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 17 1950	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE J. B. Sasata	
25. FUNERAL DIRECTOR'S SIGNATURE Bessie M. Nichols		ADDRESS 431 Union Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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

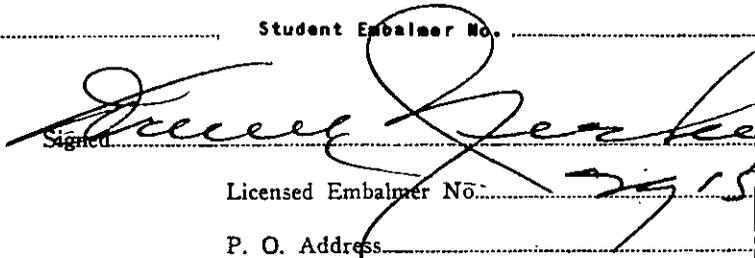
STATEMENT BY LICENSED EMBALMER

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.

Signed.....
Student Embalmer

Signed .....
Licensed Embalmer No. 2915.....
P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.