

FILED NOV 15 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **10499**

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>4007 Cleveland Ave.</b>	

3. NAME OF DECEASED (Type or print) First <b>ANGELO</b> Middle <b>MICHAEL</b> Last <b>CALABRESE</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1884</b>		9. AGE (In years last birthday) <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Custom Tailor (Retired 1 Yr.)</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Flaviano Calabrese</b>		13b. MOTHER'S MAIDEN NAME <b>Rose DeFeo</b>		14. NAME OF HUSBAND OR WIFE <b>Margherita Calabrese</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>499-36-1471</b>		17. INFORMANT Address <b>Margherita Calabrese 4007 Cleveland</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia Bilateral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
DUE TO (b) <b>Emphysema &amp; Chronic Bronchitis</b>		
DUE TO (c) <b>502.0</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <b>Prostatectomy - Post Operative.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART-II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Sept 56</b> to <b>Nov 3, 1957</b> and last saw him alive on <b>Nov 3, 1957</b>		Death occurred at <b>7:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>Alpha McKern, M.D.</b>		22b. ADDRESS <b>634 N. Grand Blvd</b>		22c. DATE SIGNED <b>11-5-57</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 7, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
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24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 5 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Paul Smith, M.D.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

