

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007875
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1811**

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 2139 E. College Avenue		Length of stay in lb 1 yr	
d. STREET ADDRESS 2139 E. College Avenue		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Stragliati			4. DATE OF DEATH Month Feb Day 14 Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 3 1898
9. AGE (In years last birthday) 60		10. FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Mundet Cork Corp	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Joseph Stragliati	
13b. MOTHER'S MAIDEN NAME Sarah - - - -		14. NAME OF HUSBAND OR WIFE Pauline M. Stragliati	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES 1st World War		16. SOCIAL SECURITY NO. 494-09-4077	17. INFORMANT Address Mrs. Pauline M. Stragliati, 2139 E. College
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of kidney (prob.) with metastases			INTERVAL BETWEEN ONSET AND DEATH 10 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 February 8, 1958 , to Feb. 13, 1958 and last saw him alive on Feb. 13, 1958 Death occurred at 2:05 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Maxwell Clutterbuck, M.D.		22b. ADDRESS 4110 West Florissant Ave.	
22c. DATE SIGNED Feb. 15, 1958			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Feb 17, 1958	23c. NAME OF CEMETERY OR CREMATORY National Cemetery
23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri			
24. FUNERAL DIRECTOR Math Hermann & Son, I c., 2161 E. Fair		25. DATE RECD. BY LOCAL REG. FEB 15 58	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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
Signature of Student Embalmer

Signed *Clement M. May*

Licensed Embalmer No. *3738*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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