

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

**FILED VS SEP 4 1959**

**59-030418**

REGISTRATION DISTRICT NO. \_\_\_\_\_ PRIMARY REGISTRATION DISTRICT NO. \_\_\_\_\_ REGISTRAR'S NO. **2 7705** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Enroute City Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>California</b> b. COUNTY <b>Los Angeles</b>  c. CITY OR TOWN <b>Alhambra</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>3124 Popler, Blvd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>Maurice</b> Middle <b>A.</b> Last <b>Giovanazi</b>	<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>18</b> Year <b>1959</b>
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<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10/10/1890</b>	<b>9. AGE</b> (last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Employee</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	<b>11. BIRTHPLACE</b> (City and state or country) <b>Victoria, Texas.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>Anthony Giovanazi</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Christine Gobi</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Bernice</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No.	<b>16. SOCIAL SECURITY NO.</b> <b>551-09-4909</b>	<b>17. INFORMANT</b> Address <b>Bernice Giovanazi, 3124 Popler, Blvd.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH _____
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>[Signature]</i>	<b>22b. ADDRESS</b> <b>1300 Clark</b>	<b>22c. DATE SIGNED</b> <b>8/19/59</b>
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<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> Removal	<b>23b. DATE</b> <b>8-19-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Los Angeles, California.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 19 59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address \_\_\_\_\_

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.