

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D JUL 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

21170  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Howe Primary Registration District No. 1802 Registered No. 2438  
 (c) City St. Louis (d) Street No. McDon Hospit St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm Charbano (Wm. Charbano)  
 (a) Residence, No. 2910 Walnut St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hadip Charbano  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25-1893  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 11 29  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cook  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis  
 13. NAME Wm Charbano  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y.  
 15. MAIDEN NAME Rhoda Hinkle  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y.  
 17. INFORMANT (ADDRESS) Record Clerk  
McDon Hospit  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn DATE June 17 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Wagner  
J. K. E. Co.  
 20. FILED June 15 1939 M. M. Crowe, Esq.  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-15-39  
 22. I HEREBY CERTIFY, That I attended deceased from 5-23-39 to 6-15-39  
 I last saw him live on 6-15-39 Death is said to have occurred on the date stated above, at 7:30 p.  
 The principal cause of death and related causes of importance were as follows:  
Bronchectasis; Chronic Date of onset \_\_\_\_\_  
vascular Nephritis  
131  
 Other contributory causes of importance: Pulmonary Edema  
& congestion  
 Name of operating \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) P. F. De Maria, M. D.  
 (Address) 547 K. C. Genl Hospit

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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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**