

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.

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: Faith Hospital, 2800. N. Taylor Ave
(d) Length of stay: In hospital or institution 45 YEARS

3. (a) PRINT FULL NAME David E. Tonella.
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Delia Tonella. 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased June 24th 1874

8. AGE: Years 65 Months 57 Days 112 If less than one day hr. _____ min _____

9. Birthplace Switzerland

10. Usual occupation Restaurant Owner Retired

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Tonella.
13. Birthplace Switzerland.
14. Maiden name Josephine Beria.
15. Birthplace Switzerland.

16. (a) Informant's own signature Delia Tonella
(b) Address 238 So. Newstead Ave

17. (a) Burial (b) Date thereof Feb. 10-1940
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd. +

19. (a) FEB 8 1940 (b) J. F. [Signature]

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis.
(d) Street No. 238 So. Newstead Ave.
(e) If foreign born, how long in U. S. A. 45 YEARS years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 6th.
year 1940 hour 4 minute 50 P. M.

21. I hereby certify that I attended the deceased from 2-5-1940 to 2-6-1940
that I last saw him alive on Feb. 6
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Duration 6-24 hrs
Bronchitis
Due to Pneumonia, central lgs. type? 6 hrs.!!
Due to Myocarditis, etc.

Other conditions Optic atrophy - Tubercles 14-16 yrs
N.B. Pt. moribund when seen

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy 80

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury T
23. Signature [Signature] (CAPY) (M.D. or other) _____
Address 462 N. Taylor Date signed 2/7/40

On the case
462 N Taylor

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 W H Van Metre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.