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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 25 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26757
Registrar's No. 6653

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3959 Palm St. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 8 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County
(c) City or town St. Louis 10
(If outside city or town limits, write "RURAL")
(d) Street No. 3959 Palm St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Nathan Dunbracco 5 16

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 Emma Dunbracco
6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased April (Month) 9. (Day) 1873 (Year)

8. AGE: Years 67 Months 3 Days 26 If less than one day hr. min.

9. Birthplace Baltimore (City, town, or county) Maryland (State or foreign country) 1

10. Usual occupation Owner of Cigar Counter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name Emma (Unknown)
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant's own signature Mrs Emma Dunbracco
(b) Address 3959 Palm St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7, 1940. (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery.

18. (a) Signature of funeral director Wm. M. Schumacher
(b) Address 4834 Natural Bridge.

19. (a) AUG 5 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4, year 1940 hour 11 minute 10 A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Primary Occlusion	
Due to	
Due to Arterial Sclerosis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 946	

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Alfred G Perry (M. D. or other)
Address Deputy Coroner Date signed 8/5/40

(Licensed Embalmer's Statement on Reverse Side)

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 John Ketter

Licensed Embalmer No. 3880

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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