No. 2
-10-39
7-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33105

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1813

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether In this community 35 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 3010 Washington Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Peter Polete

3. (b) If veteran, name war ____

3. (c) Social Security No. 494-10-7842

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife ____

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased June (Month) 14 (Day) 1895 (Year)

8. AGE: Years 45 Months 3 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace Washington Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Zeno Polete
13. Birthplace Washington Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Julia Trakey
15. Birthplace Washington Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Joseph Dwyer

(b) Address 2331 Mullanphy St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-40 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Cullen & Kelly

(b) Address 1416 N. Taylor ave.

19. (a) SEP 25 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 23 year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from September 11, 1940, to September 23, 1940 that I last saw him alive on September 23, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Pulmonary Tuberculosis	
Due to	
Due to 23	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Chronic Pulmonary Tuberculosis	

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 Herbert F. Schwartz (M. D. ~~or other~~)

Address Robert Koch Hospital Date signed 9.25.40

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

City License #145

Signed Glenn E. Anderson

Licensed Embalmer No. 4141

P. O. Address St. Louis Mo.

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.