

Reg. on District No. **230**

Primary Registration District No. **4140**

Registrar's No. **497**

1. PLACE OF DEATH:
(a) County **Crawford**
(b) City or town **Cuba**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Marion**
(c) City or town **Belle**
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? **1** years.

3. (a) PRINT FULL NAME **Dominick Trettenaro**
(b) If veteran, name war _____ (c) Social Security No. **495-16-3879**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **MAR.** day **2nd** year **1941** hour **9** minute **40 P.M.**

4. Sex **Male** **5. Color or race** **white** **6. (a) Single, widowed, married, divorced** **married**
7. (b) Name of husband or wife **Mary Trettenaro** **8. (c) Age of husband or wife if alive** _____ years
9. Birth date of deceased **Sept. 29th 1893**
(Month) (Day) (Year)

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

8. AGE: Years **47** Months **5** Days **3** If less than one day _____ hr. _____ min.

Immediate cause of death **Unavoidable accident by automobile**
Duration _____

9. Birthplace **Unknown Italy**
(City, town, or county) (State or foreign country)

Due to _____
Due to _____

10. Usual occupation **Supervisor**

Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business **Building**

Major findings: _____
Of operations _____

MOTHER FATHER
12. Name **Angela Trettenaro**
13. Birthplace **Schio Prov. Italy**
(City, town, or county) (State or foreign country)
14. Maiden name **SIACOMA MARTESE**
15. Birthplace **Schio Prov. Italy**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Angela Trettenaro**
(b) Address **ST. JAMES, MO.**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **accident by automobile**
(b) Date of occurrence **March 2, 1941**

17. (a) Burial (b) Date thereof **MAR. 5, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **ST. LOUIS, MO.**

(c) Where did injury occur? **Cuba Crawford Mo**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **20 Kubler Highway**
(Specify type of place) **3**
While at work? **no** **(e) Means of injury** _____

18. (a) Signature of funeral director **Earl Kiehl**
(b) Address **St. James, Mo.**

23. Signature **J. J. A. Herzog** (M. D., or other) **Crowner**
Address **Shelville Mo** **Date signed** **3/2-41**

19. (a) Mar. 4, 1941 (b) **J. J. A. Herzog**
(Date received local registrar) (Registrar's signature)

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

2
0-39
-39
21492

JUN 28 1941

JUN 30 1941

JUL 3 1941

17026
98

FEB 26 1945

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.

Registration District No. 230

Primary Registration District No. 4140

Registrar's No. 49

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
Crawford Steelville, Mo.

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Cuba
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Dorinich Jetteneers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2
year _____ hour _____ minute _____ 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.

Immediate cause of death: unavoidable accident by automobile on State Highway #66 while walking across highway and being struck by automobile.

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

