

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31539

Registration District No. 170

Primary Registration District No. 170

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Station Hospital, Ft. Leonard Wood, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution DOA
In this community Transient 3 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State New Jersey (b) County 197
(c) City or town New Brunswick 28
(If outside city or town limits, write "RURAL")
(d) Street No. 168 Easton St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Angelo (NMI) Catalfamo Sgt.

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

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased February 28 1919
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
24 6 8 --- hr. --- min.

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

10. Usual occupation U.S. AAC 32555358

11. Industry or business Reeves Prov. Gp-346 Bomb Gp.

MOTHER FATHER { 12. Name Andrew Catalfamo
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Minnie
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant U.S. Army Records

(b) Address Army Air Base, Dyersburg, Tenn.

17. (a) Removal (b) Date thereof Sept. 8 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director W.E. Halman

(b) Address Lebanon Mo

19. (a) Sept 7, 1943 (b) Robert A. Murray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
year 1943 hour about 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from ---
---, 19---, to ---, 19---;

that I last saw him alive on ---, 19---;
and that death occurred on the date and hour stated above.

Immediate cause of death Multiple contusions, lacerations and fractures

Due to Airplane Crash

Due to ---
Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
Of operations ---

Of autopsy None

Duration

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) Accident 233

(b) Date of occurrence Sept. 4, 1943

(c) Where did injury occur? Rural Dent Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Rural-airplane crash

While at work? Yes (Specify type of place) airplane & ground
(e) Means of injury

23. Signature Robert A. Murray (M. D. or other) 48

Address Ft. Leonard Wood, Mo. Date signed Sept 7, 1943

RECEIVED

District Health Officer No. 3

District File Number 948578

Date Filed 9.21-43

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.

Signed W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Zebanon N.

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, fact should be so stated above:

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 100

Primary Registration District No. 5385

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Deer
(b) City or town Rural Meramec Twp
(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 Angela (nm) Catalano

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

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Feb 28
(Month) (Day) (Year)

8. AGE: Years 24 Months 6 Days _____ If less than one day _____ 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 _____

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

16. (a) Informant _____

(b) Address _____

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

(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 Feb year 1943 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY - USE INK - FILLING IN DELETED SPACES - MAKE A PERMANENT RECORD

31539