

S. No. 2
M-5-43
5-17-39
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FILED JAN 11 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11625**

1. PLACE OF DEATH:

(a) County..... *St Louis*

(b) City or town..... *St Louis*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4901 Beacon 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 *Mo* (b) County *001* *17*

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

(d) Street No. *4901 Beacon 7* *9*
(If rural, give location)

(e) Citizen of foreign country?..... *0* (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME *LOUIS GALLI*

3. (b) If veteran, name war..... *no*

3. (c) Social Security No. *none*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *29*
year *1945* hour *11* minute *25 P* M.

4. Sex *male* 5. Color *white*

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

6. (c) Name of husband or wife *Pa Galli* 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased *Jan 19 1893*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Dec 27* 19*45* to *Dec 29* 19*45* that I last saw him live on *Dec 29* 19*45* and that death occurred on the date and hour stated above.

8. AGE: Years *50* Months *10* Days *10* If less than one day hr. min.

Immediate cause of death *Coronary Thrombosis* Duration *1 hr*

9. Birthplace..... *Siltwater Mo* (City, town, or county) (State or foreign country)

Due to..... *Chronic Hypertension*

Due to..... *Heart Disease*

10. Usual occupation..... *merchant*

11. Industry or business.....

12. Name..... *Charles Galli*

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

14. Maiden name..... *Caroline Galli* (State or foreign country)

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

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

Major findings: *93*

Of operations.....

Of autopsy.....

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

16. (a) Informant *Mr Charles Galli*

(b) Address *4901 Beacon Ave*

17. (c) *burial* (b) Date thereof *Jan 2 1946*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Calvary Cemetery*

18. (a) Signature of funeral director *Ray J. Calcutt*

(b) Address *5142 Dagg St Ave*

19. (a) *JAN 1 1946* (b) *Dr. Fred*
(Date received local registrar) (Registrar's signature)

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 *0*

23. Signature *Ray J. Calcutt*
Address *6073 Siltwater* Date signed *12-31-45*

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

MOTHER FATHER

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.....

Samuel Calcaterra

Licensed Embalmer No.....

2376

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, fact should be so stated above.