

S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

18271

State File No.

3997

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

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:
1436 Clara Avenue.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County STL
 (c) City or town St. Louis ~~(287)~~
(If outside city or town limits, write "RURAL")
 (d) Street No. 1436 Clara Avenue.
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Daniel Cerone.
 3. (b) If veteran, name war None
 3. (c) Social Security No. No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 1st.
 year 1946 hour 3 minute 30 A.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Rose Cerone.
 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased November 4, 1875.
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 12 1946 to May 1 1946
 that I last saw him alive on Apr 12 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>5</u>	<u>27</u>	hr. min.

Immediate cause of death Chor. Myocarditis
 Due to Arterio Sclerosis
 Due to 93

9. Birthplace Italy
(City, town, or county) (State or foreign country)
 10. Usual occupation Laborer.

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations No
 Of autopsy No

MOTHER FATHER
 11. Industry or business Peter Ceron.
 12. Name Peter Ceron.
 13. Birthplace Italy.
(City, town, or county) (State or foreign country)
 14. Maiden name Italy.
(City, town, or county) (State or foreign country)
 15. Birthplace Italy.
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mr. Peter Cerone.
 (b) Address 4055 Maffett Avenue.
 17. (a) Burial (b) Date thereof 5-4-1946.
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery.

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.....

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.
 (b) Address 5966-68 Easton Avenue.
 19. (a) MAY 2 1946
(Date filed in local registrar)
J. F. Breda
(Registrar's signature)

23. Signature Mr. J. Langan (M. D. or other)
 Address 5803 Plymouth Date signed May 1-46

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

14100

Dr. Langan.
5803 Plymouth Avenue.
Hours 12 to 1 P.M.
Telephone Cabanne 0220

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 *Salmon M. Mearns*.....

Licensed Embalmer No. *2732*.....

P. O. Address. *St. Louis*.....

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.