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DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
FILED AUG 20 1946  
7382

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28565

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7087

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff Memorial  
(d) Length of stay: In hospital or institution 29 days  
In this community 45 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 26<sup>th</sup>  
(c) City or town St. Louis  
(d) Street No. 1512 Destrahan St.,  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country

3. (a) PRINT FULL NAME FRANK CROSS  
3. (b) If veteran, name war  
3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 13th  
year 1946 hour 3:50 minute P M.  
21. I hereby certify that I attended the deceased from July 15th  
19 46 to August 13th 19 46  
that I last saw him alive on August 13th 19 46  
and that death occurred on the date and hour stated above.

4. Sex Male 0  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive 80 years  
7. Birth date of deceased May 3rd, 1946 1870

Immediate cause of death  
Cerebral vascular accident  
Due to general paresis  
Duration

8. AGE: Years 76 Months 3 Days 5  
If less than one day hr. min.

9. Birthplace Missouri (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  
Of autopsy  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
PHYSICIAN Underline the cause to which death should be charged statistically.

11. Industry or business  
12. Name Tout Cross  
13. Birthplace Missouri (City, town, or county) (State or foreign country)  
14. Maiden name Mary Johnson  
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Laura Cross  
(b) Address 1512 Destrahan

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16th, 1946  
(c) Place: burial or cremation Memorial Park

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 Edward Koch  
(b) Address 3516 N. 14th St.  
19. (a) AUG 14 1946 (Date received local registrar)  
J. F. Bredeck (Registrar's signature)

23. Signature Thomas Thely M.D. (M. D. or other) M.D.  
Address 3673 Pottery Date signed 8/14/46

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

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**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 Ronald O. Galante

Licensed Embalmer No. 3917

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 280-65Registrar's No. 7081Registration District No. 318Primary Registration District No. 1003

## 1. PLACE OF DEATH:

- (a) County.....  
 (b) City or town St. Louis  
 (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 Frank Cioni

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 \_\_\_\_\_ years

7. Birth date of deceased May 3  
 (Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

## 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 \_\_\_\_\_  
 (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 April 1946 year \_\_\_\_\_  
 \_\_\_\_\_ month \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration

- Due to Psychosis with syphilitic meningitis - Encephalitis  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_Of autopsy 30 B

## 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 Thomas J. Hall, M.D. (M.D. or other)  
 Address 1920 E. Cotton St. St. Louis Date signed 10/12/46

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

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SUPPLEMENTARY

