

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6323**
Registrar's No. **1931**

FILED MAR 11 1948

Registration District No. **318** Primary Registration District No. **100**

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

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:
St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... life (Specify whether
In this community..... life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME..... SALVATORE ELIA
3. (b) If veteran, name war..... **3. (c) Social Security** No.....

4. Sex M **5. Color or** W
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..... February 19, 1948
(Month) (Day) (Year)

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

9. Birthplace..... St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation..... Infant

11. Industry or business.....

MOTHER FATHER

12. Name..... Salvatore Elia
13. Birthplace..... St. Louis, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name..... Freida Russell
15. Birthplace..... Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant..... Salvatore Elia
(b) Address..... 2709 McNair Avenue

17. (a)..... burial **(b) Date thereof**..... 2-23-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... Mount Hope Cemetery

18. (a) Signature of funeral director..... A.W. McLaughlin
(b) Address..... 2301 Lafayette Avenue

19. (a)..... FEB 26 1948 **(b) J. F. Bredesch**
(Date received local health officer's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... Missouri (b) County..... 000
(c) City or town..... St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No..... 2709 McNair Avenue 9
23 (If rural, give location)
(e) Citizen of foreign country?..... no (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 22 day 22 nd
year..... 1948 hour..... 7:10 minute..... 0 a. M.
21. I hereby certify that I attended the deceased from
2/19/48 to 2/22/48, 1948;
that I last saw him alive on 2/21/48, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Suba-cerebral hemorrhage > 2 hrs.
Due to Possible birth injury
from forceps
Other conditions (include pregnancy within 3 months of death)
160

Duration

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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..... W. F. Neuman (M. D. or other)
5203 Chipman Address 2/23/48 Date signed

1967

Dr. W.F. Nuen
(Off) 5203 Chippewa Street
(Res) 5862 Delor Street

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 *W. F. Nuen*

Licensed Embalmer No. 3830

P. O. Address 2901 Lafayette

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.