

FILED JUN 21 1948

Registration District No. 018

Primary Registration District No. 1005

Registrar's No. 5309

1. PLACE OF DEATH: **SP. LODG**
(a) County: **St. Louis**
(b) City or town: **St. Louis, Missouri, Ill.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. John's Hospital 0**
(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: **CHARLES CHEVIVI**
3. (b) If veteran, name war: **No**
3. (c) Social Security No. _____

4. Sex: **Male 0**
5. Color or race: **White**
6. (a) Single, widowed, married, divorced: **married**
6. (b) Name of husband or wife: **Josephine COLONI**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Feb 27 1884**
(Month) (Day) (Year)

8. AGE: Years **64** Months **8** Days **13**
If less than one day _____ hr. _____ min.

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

10. Usual occupation: **Janitor**

11. Industry or business: _____

MOTHER FATHER
12. Name: **Unknown**
13. Birthplace: **Italy**
(City, town, or county) (State or foreign country)
14. Maiden name: **Unknown**
15. Birthplace: **Italy**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Josephine Chevivi**
(b) Address: **Herrin, Ill.**

17. (a) **Burial** (b) Date thereof: **June 14 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Resurrection**

18. (a) Signature of funeral director: **Paul C. Calcaterra**

(b) Address: **5142 Daggett Ave.**

19. (a) **JUN 10 1948** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
State: **Illinois** (b) County: **99th**
(c) City or town: **Herrin Illinois**
(If outside city or town limits, write "RURAL")
(d) Street No.: **1205** **Monroe Ave.**
N.R. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **2**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June**, day **10th**, year **1948** hour **5** minute **45 AM**

21. I hereby certify that I attended the deceased from **May 29 1948** to **June 10 1948**; that I last saw him alive on **June 9 1948**; and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of stomach** Duration: **89 mo 7**

Due to: _____
Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **Carcinoma of stomach**
Of operations: **Resection**
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? _____
(Specify type of place) _____
(e) Means of injury _____

23. Signature: **Charles Montani** (M. D. or other) **MD**
Address: **5147 Daggett Ave.** Date signed: **6-10-48**

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

300
47
39
398

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 *Paul C. Calcaterra*

Licensed Embalmer No. *2376*

P. O. Address *5142 Daggett*

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.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County..... St. Louis, Mo

(b) City or town..... St. Louis, Mo
(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..... Charles Chevivi

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.....

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

7. Birth date of deceased..... Jul 27
(Month) (Day) (Year)

8. AGE: Years..... 64 Months..... 3 Days..... 1 If less than one day, hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bradeck
JUL 24 1948 (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..... July
year..... 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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).....

(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)
Date signed.....

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

SUPPLEMENTARY

S-20746

1