

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **517**

Primary Registration District No. **6576**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Koch (rural)**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1616 days**
(Specify whether years, months or days)

In this community **31 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **0311**

(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")

(d) Street No. **2225 Montgomery** **1**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **TANCREDI, JAMES**

3. (b) If veteran, name war _____

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

4. Sex **Male** 0 5. Color or race **White**

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

6. (b) Name of husband or wife **Susie Jenkinson Tancredi** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 5 1884**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	7	4	hr. _____ min.

9. Birthplace **Italy** 5
(City, town, or county) (State or foreign country)

10. Usual occupation **Coal Miner**

11. Industry or business _____

12. Name **Roco Tancredi**

13. Birthplace **Italy** 5
(City, town, or county) (State or foreign country)

14. Maiden name **Lucia Russa**

15. Birthplace **Italy** 5
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records**

(b) Address **Robert Koch Hospital**

17. (a) **BURIAL** (b) Date thereof **12-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Quillan-Rally**

(b) Address **4386 Lindell**

19. (a) **2-16-48** (b) **Richard L. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **9**
year **1948** hour **10** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **6-27-44**, 19____, to **12-9-48**, 19____;
that I last saw him alive on **12-9-48**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis** Duration **???**

Due to _____

Due to **13 5**

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

Major findings:
Of operations _____

Of autopsy _____

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**

Signature **R. J. ...** (M. D. or other) **4-1**

Address **Robert Koch Hospital** Date signed **12/11/48**

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 Ralph W Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, Mo.

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. ;