

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10042
State File No. 2708
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital		d. STREET ADDRESS (If rural, give location) 4924 Berthold Ave.		
3. NAME OF DECEASED (Type or Print) JOSEPH		a. (First) b. (Middle) c. (Last) FONTANA	4. DATE OF DEATH (Month) (Day) (Year) March 24 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH March 9, 1881	9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months 0 Days 15 IF UNDER 12 HRS. Hours Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis		11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Girolmo Fontana		
13b. MOTHER'S MAIDEN NAME Anne Unknown		14. NAME OF HUSBAND OR WIFE Late Mary Fontana		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Angeline Catanzaro
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis, (Embolic) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes mellitus DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Amputated		INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs? 1 month
19a. DATE OF OPERATION 3/8/49		19b. MAJOR FINDINGS OF OPERATION Gangrene of rt. leg. (recovered)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Feb 19, 1949 to Mar 24, 1949, that I last saw the deceased alive on 2-23-1949, and that death occurred at 9:50 a.m., from the causes and on the date stated above.				
23a. SIGNATURE Charles Sherwin		23b. ADDRESS 3720 Washington		23c. DATE SIGNED 3/23/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 28, 1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. MAR 25 1949		REGISTRAR'S SIGNATURE J. B. Luciani		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser
				ADDRESS 4228 S. Kingshighway Bl.

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

Dr. [unclear] [unclear]
3720 Washington 3-1

[Handwritten mark]

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Richard W. Stovesand

Signed _____
Student Embalmer

Licensed Embalmer No. 4007

P. O. Address _____

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.