

FILED JUL 18 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 25354
 5895

318

1003

Registrar's No.

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

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		No 2139					
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)							
3. NAME OF DECEASED a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)					
angela		Travaglini				7-5-50					
5. SEX		6. COLOR OF RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH					
female		white		widow		about 63					
9a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
house wife						Italy		USA			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
unknown			unknown			Joseph Travagline					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME			ADDRESS		
no			no			Charles Travagline					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)						INTERVAL BETWEEN ONSET AND DEATH			
		Chronic Myocarditis						1 year 8 months			
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						years			
		DUE TO (b) Hypertensive Cardiovascular disease									
		DUE TO (c)									
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?				H/OX			
22. I hereby certify that I attended the deceased from 10-26, 1948, to 7-5, 1950, that I last saw the deceased alive on 7-5, 1950, and that death occurred at 11:30pm., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title)				23b. ADDRESS			23c. DATE SIGNED				
Charles Montani, M.D.				5147 Daggettar			7-6-50				
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)					
burial		July 8		Resurrection		St Louis		Mo			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS	
JUL 7 1950		J. B. Foster			Daryl C. Calcaterra						

P. L. Tamm 9/4/00

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 me

working under my personal supervision.

Student Embalmer No.

Signed William J. Tamm

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles 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.