

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21694**
Registrar's No. **5724**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis	c. LENGTH OF STAY (in this place) Police	c. CITY (If outside corporate limits, write RURAL and give township) Crystal City 0501	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) 200 Olive St. /	

3. NAME OF DECEASED (Type or Print) a. (First) Constantino b. (Middle) - c. (Last) Aghello	4. DATE OF DEATH (Month) (Day) (Year) 6-19-1952
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June 7, 1884	9. AGE (In years last birthday) 68	# UNDER 1 YEAR Months Days	# UNDER 1 M. OR L. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Worker	10b. KIND OF BUSINESS OR INDUSTRY P. P. G. Co.	11. BIRTHPLACE (City and State or Foreign Country) Sagata, Italy 5	12. CITIZEN OF WHAT COUNTRY? Italy
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13a. FATHER'S NAME Anthony Agnello	13b. MOTHER'S MAIDEN NAME Mary Lamanica	14. NAME OF HUSBAND OR WIFE ✓
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Tommy Gabriel Crystal City, Mo	ADDRESS Crystal City, Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Cardio-vascular renal disease rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension was decreased			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 442X
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22. I hereby certify that I attended the deceased from **6/10**, 19**52**, to **6/19/52**, that I last saw the deceased alive on **6/18/52**, and that death occurred at **22 m.**, from the causes and on the date stated above.

23a. SIGNATURE W. A. ...	(Degree or title)	23b. ADDRESS 3604 ...	23c. DATE SIGNED 6/19/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-23-52	24c. NAME OF CEMETERY OR CREMATORY XXXXXXXXXXXXXX	24d. LOCATION (City, town, or county) (State) Bellevoe, Ohio
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DATE REC'D BY LOCAL REG. JUN 20 1952	REGISTRAR'S SIGNATURE J. Carl Smith Mo	FUNERAL DIRECTOR'S SIGNATURE R. Politti Crystal City, Mo	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Student
Student Embalmer

Signed Gentry R. Politte

Licensed Embalmer No. 3481

P. O. Address Crystal City, 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.