

Subscribed
FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20182

State File No. _____

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

Registrar's No. **4632**

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 5345 Wilson | | d. STREET ADDRESS (If rural, give location) 13 5345 Wilson | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Angelo | | b. (Middle) | c. (Last) Belloli |
| 4. DATE OF DEATH (Month) (Day) (Year) May 22, 1954 | | 5. SEX Male | |
| 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH Jan. 7, 1888 | 9. AGE (In years last birthday) 66 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Italy | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Margaretta |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 489-01-5917 | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Angeline Herwick, 5345 Wilson | |
| 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) Cerebral thrombosis ANTECEDENT CAUSES DUE TO (b) Cerebral arteriosclerosis years DUE TO (c) Generalized arteriosclerosis years 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) 332 X | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 11-17, 1953 , to 5-22, 1954 , that I last saw the deceased alive on 5-21, 1954 , and that death occurred at 5:30 pm. , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE Charles Montani M.D. | | 23b. ADDRESS 5147 Daggetton | 23c. DATE SIGNED 5-23-54 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 5-25-54 | 24c. NAME OF CEMETERY OR CREMATORY Resurrection | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
| DATE REC'D BY LOCAL REG. MAY 24 1954 | REGISTRAR'S SIGNATURE Charles Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calcaterra Funeral Home, 5140 Dagget |

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 _____

John J. Kaines
Licensed Embalmer No. 4108

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.