

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25513**

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

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>541</b>		Registrar's No. <b>1830</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton, Mo.</b>		c. LENGTH OF STAY (In this place) <b>1 Hour</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>1299 Hodiamont</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Pete</b>		b. (Middle) _____		c. (Last) <b>Demme</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>7 24 54</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept. 1891</b>	
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Days _____		IF UNDER 48 HRS. Hours _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Sicily, Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13a. FATHER'S NAME <b>Leslie Demme</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Manno</b>		14. NAME OF HUSBAND OR WIFE <b>Lillian Demme</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lillian Demme 1299 Hodiamont</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL VASCULAR ACCIDENT</b>				INTERVAL BETWEEN ONSET AND DEATH <b>ONE Hour</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 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) <b>331X</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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 <b>7-24 1954</b> , to <b>7-24 1954</b> , that I last saw the deceased alive on <b>7-24 1954</b> , and that death occurred at <b>2:41 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Robert E. New MD.</b>				23b. ADDRESS <b>601 So. Brentwood</b>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVED</b>		24b. DATE <b>July 27, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>7/26/54</b>		REGISTRAR'S SIGNATURE <b>Robert R. Romke MD.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>P. Miceli 1150 No. Kingshighway</b>			

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✓ **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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

**If this body is not embalmed, fact should be so stated above.**