

FILED NOV 22 1957

## STANDARD CERTIFICATE OF DEATH

12865

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 2768

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLAYTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>JENNINGS 4138</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST LOUIS COUNTY</b>		Length of stay in 1b <b>1 WEEK</b>	d. STREET ADDRESS (If outside, give location) <b>8824 CORWIN DR.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NICOLA</b> Middle <b>GENOVA</b> Last <b>GENOVA</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>	9. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____
11. BIRTHPLACE (City and state or country) <b>SANFALICIA ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SERAPHINO GENOVA</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>500-12-9192</b>	17. INFORMANT Address <b>PHOEBE WILBANKS 8824 CORWIN DR.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease, decompensated</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Vascular Thrombosis</b> DUE TO (c) <b>Broncho pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10/21/57</b> <b>11/5/57</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>10-28-57</b> to <b>11-5-57</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>11-5-57</b> Death occurred at <b>8<sup>10</sup></b> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Angelo A. Speno M.D.</b>		22b. ADDRESS <b>601 S. Brentwood Clayton, Mo.</b>	22c. DATE SIGNED <b>11-5-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-8-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FEE FEE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>PATTONVILLE MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>EARL HILLEMANN FUNERAL HOME 9709 LACKLAND</b>		25. DATE RECD. BY LOCAL REG. <b>11-7-57</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Danke Mo</b>

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. 300  
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

Securing the medical certificate in the same manner required by 193.140 MORs 1949.

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 *Earl J. Hillman*

Licensed Embalmer No. *350*

P. O. Address *Oreland*

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.