

FILED MAR 20 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2290

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Macoupin 999**
(c) City or town **Benld**
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) **2**
If yes, name country.....

3. (a) PRINT FULL NAME **Pete Macio Corgiat**

3. (b) If veteran, name war **No**
3. (c) Social Security No. **343-05-2124**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Antonio Corgiat**
6. (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **December 25 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 2 11 hr. min.

9. Birthplace **Corio Italy 5**
(City, town, or county) (State or foreign country)

10. Usual occupation **Coal Miner**

11. Industry or business.....

12. Name **Bernard Corgiat 5**

13. Birthplace **Italy 5**
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Rua**

15. Birthplace **Italy 5**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emil Corgiat**

(b) Address **Benld, Illinois.**

17. (a) **Removal** (b) Date thereof **3-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Benld, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **MAR 8 1946** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **6**
year **1946** hour **7** minute **25 P.** M.
21. I hereby certify that I attended the deceased from **March 4-1946**
March 6 19**46** to **March 6** 19**46**
that I last saw him alive on **March 6** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Intestinal Obstruction 2 days
chronic myocarditis 26 hrs
Due to **chronic myocarditis 26 hrs**
Due to **122 hrs**
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations **Intestinal obstruction**
Of autopsy **none**
PHYSICIAN.....
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(b) Date of occurrence.....
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work?..... (e) Means of injury **C**
23. Signature **[Signature]** (M. D. or other) **MD**
Address **3218 8th Street** Date signed **3-9-46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
9929

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *John Agonowski*
.....
Licensed Embalmer No. *3398*
.....
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 this body is not embalmed, fact should be so stated above.