

FILED FEB 20 1948
Registration District No. 918

Primary Registration District No. 1002

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

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: Enroute City Hospital 3
(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..... 000

(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 615 Walnut St.
25- (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Louis Alesio Scire

3. (b) If veteran, name war..... World War II

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced..... Divorced

6. (b) Name of husband or wife..... Unknown

6. (c) Age of husband or wife if alive..... Unk. years

7. Birth date of deceased..... February 6, 1913
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>34</u>	<u>11</u>	<u>25</u>hr.min.

9. Birthplace..... Benld, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation..... Cook

11. Industry or business.....

12. Name..... Mike Scire

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

14. Maiden name..... Emma Soukup

15. Birthplace..... Bohemia
(City, town, or county) (State or foreign country)

16. (a) Informant..... Chester Scire

(b) Address..... Benld, Ill.

17. (a) Removal (b) Date thereof..... 2-3-48
(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) FEB 3 1948 (b) J. F. Proctor
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Feb. day..... 1
year..... 1948 hour..... 7 minute..... 41 M.

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;
that I last saw him..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death..... Impacted fracture of skull
when he fell over the
Missouri Transfer Station
managed by Alfred Steinberg
Engineer and Portland Cement
Station at Broadway and Taylor
Street around 7:30 P.M. Jan
31, 1948

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN.....
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)..... Accident

(b) Date of occurrence..... Jan 31 1948

(c) Where did injury occur?..... St. Louis, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... Public Street
(Specify name of place)

While at work..... (Specify name of place)

23. Signature..... Petrick & Taylor (M.D. or other)..... 3

Address..... Dep. Coroner Date signed..... 2/3/48

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.....

G. W. Wilkinson

Licensed Embalmer No.....

3575

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.