

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7969
Registrar's No. 2185

FILED MAR 16 1945
Registration District No. 318

Primary Registration District No. 1007

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: CHRISTIAN HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 HRS.
(Specify whether _____)
In this community LIFE.
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2611 SHATTERY ST.
(If rural, give location) _____
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME MICHAEL LUCIDO.

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MARCH 5TH. 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. _____ min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation CHILD.

11. Industry or business _____

12. Name PHILIP LUCIDO.

13. Birthplace ST. LOUIS MISSOURI.
(City, town, or county) (State or foreign country)

14. Maiden name LOTTIE PENKALA

16. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

18. (a) Informant's own signature Jorge Macdofski

(b) Address 4707 Bouverton Ave

17. (a) BURIAL (b) Date thereof MARCH 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY.

18. (a) Signature of funeral director Brookland

(b) Address 1827 HOGAN ST.

19. (a) MAR 7 1945 J. F. Busch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 5TH.
year 1945 hour 8:05 minute _____ P. M.

21. I hereby certify that I attended the deceased from Mar. 5
1945, to Mar. 5, 1945
that I last saw him alive on Mar. 5
and that death occurred on the date and hour stated above.

Immediate cause of death Inhalation of ammonia fluid
Due to Pneumonia rupture of top of vessel.
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

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

(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 _____

23. Signature J. F. Busch (M. D. or other) _____

Address 607 N. Grand Date signed 3-6-45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39
DOM-5-1
1 X1951

MAR 7 1945

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.

No Embalming and to
Signed *Brockland*
John B. Brockland
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 this body is not embalmed, above space should be left blank.