

FILED APR 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11053**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6676** Registrar's No. **415-**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koch (rural)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		d. STREET ADDRESS (If rural, give location) 934 Beach Street	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Joseph	c. (Last) Massucci	4. DATE OF DEATH (Month) (Day) (Year) February 20, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH 6-9-83	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sold Novelties on streets	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Stephen Massucci	13b. MOTHER'S MAIDEN NAME Marie Comprona	14. NAME OF HUSBAND OR WIFE Antoinette Soma
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 495-22-7674	17. INFORMANT'S SIGNATURE OR NAME Robert Koch Hospital, Koch, Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 22 yrs (?)
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **12-24-1948**, to **2-20-1949**, that I last saw the deceased alive on **2-20-1949**, and that death occurred at **11:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Beckham, M.D.	23b. ADDRESS Robert Koch Hospital	23c. DATE SIGNED 2-21-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2/21/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. 2-21-49	REGISTRAR'S SIGNATURE Theresa L...	25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark	ADDRESS 1125 Hodiamont Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 1 1 1950

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
Student Embalmer

Signed Alfred J. Beckler

Licensed Embalmer No. 32663

P. O. Address 1125 Hodiament Ave.

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.