

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24582

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6576**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) LIFE	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Sanitarium		d. STREET ADDRESS (If rural, give location) 19-3855 DELMAR Blvd	

3. NAME OF DECEASED (Type or Print) a. (First) THERESA b. (Middle) BASORA c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 27 1949	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH JUNE 17-1886
9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 1 Days 10	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME ANDREW MORIO	13b. MOTHER'S MAIDEN NAME THERESA Potcheck	14. NAME OF HUSBAND OR WIFE Florencio
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Kate Mama 3855 Delmar Bl.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, intestines- site		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) not determined DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 46-153X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5/1/45**, 19___, to **7/27/49**, 19___, that I last saw the deceased alive on **7/27/49**, 19___, and that death occurred at **7:40P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jack R. Delman MD	23b. ADDRESS 5400 Arsenal st	23c. DATE SIGNED 7/28/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-30-49	24c. NAME OF CEMETERY OR CREMATORY LAKEWOOD PARK
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		

DATE REC'D BY LOCAL REG. 7/29 1949	REGISTRAR'S SIGNATURE J B Pascoe	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Allen W McLaughlin 23014 Fayette
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

2-11-55

Signed _____

C. W. Cooper

Licensed Embalmer No. _____

3830

P. O. Address _____

2301 Lafayette 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.