

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28296  
7695

318

1003

BIRTH NO.		REG. DIST. NO.	PRIMARY REG. DIST. NO.	Registrar's No.
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 10		
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 1 1/2		
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Hospital		e. STREET ADDRESS (If rural, give location) 26 1601 Hogan St 0		
3. NAME OF DECEASED (Type or Print) Pete Lococo		a. (First) b. (Middle) c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Sept. 4. 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 28. 1888	9. AGE (In years last birthday) 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire		10b. KIND OF BUSINESS OR INDUSTRY Fruit Dealer	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? Italy
13a. FATHER'S NAME Mike Lococo		13b. MOTHER'S MAIDEN NAME Augustine Lococo (No Relation)	14. NAME OF HUSBAND OR WIFE Guiseppa Lococo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 497-07-9799	17. INFORMANT'S SIGNATURE OR NAME ADDRESS 1601 Hogan St.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebellar Apoplexy DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 83		
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? 3344		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:15 P. m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title)		23b. ADDRESS	23c. DATE SIGNED	
24a. BURYAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept. 8, 1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE RECD. BY LOCAL REG. SEP 6	REGISTRAR'S SIGNATURE J B Pasater	FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 1431 Union Blvd.

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

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**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.

Signed *James M. Heber*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2915*

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.**