

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1950

318

1003

State File No.

4412

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	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Paul Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>5340 Lillian</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>Michael</i> b. (Middle) <i>Garofalo</i> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <i>May 15 1950</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>March 28 1898</i>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, specify if rural)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Sicily</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
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13a. FATHER'S NAME <i>Genaro Garofalo</i>	13b. MOTHER'S MAIDEN NAME <i>Gloria Bruno</i>	14. NAME OF HUSBAND OR WIFE <i>Margaret</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <i>500-18-9190</i>	17. INFORMANT'S SIGNATURE (OR NAME) ADDRESS <i>Margaret Garofalo 5340 Lillian</i>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>CORONARY Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 MO.</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>ARTERIO SCLEROSIS</i>		
	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 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) <i>St Louis MO.</i>
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? <i>H20!</i>

22. I hereby certify that I attended the deceased from *7-19* ¹⁹⁴⁹, to *4-12*, 1950, that I last saw the deceased alive on *5-14*, 1950, and that death occurred at *8:45* a.m., from the causes and on the date stated above.

23a. SIGNATURE <i>J. Ollson</i> (Degree or title)	23b. ADDRESS <i>6401 W. Florence</i>	23c. DATE SIGNED <i>5-16-50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>5-18-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>St. Paul Churchyard</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo.</i>
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DATE REC'D BY LOCAL REG. <i>MAY 17 1950</i>	REGISTRAR'S SIGNATURE <i>J. B. Pasater</i>	25. FEDERAL DIRECTOR'S SIGNATURE <i>Wm. F. Stewart</i>	ADDRESS <i>1225 Union</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

64501 N. Florissant

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 Clement M. Meany

Licensed Embalmer No. 3783

P. O. Address St. Louis

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.