

No. 300
10-48

FILED APR 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15064

State File No.

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069

Registrar's No. 893

4085

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

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3069</u>		State File No.		Registrar's No. <u>893</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton Richmond Heights</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2079			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. Marys Hosp</u>				d. STREET ADDRESS (If rural, give location) <u>5934 Drury Lane</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Giuseppe</u>		b. (Middle) _____		c. (Last) <u>Vellutini</u>		4. DATE OF DEATH (Month) <u>47</u> (Day) <u>5</u> (Year) <u>51</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 18 1873</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____		
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		5		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME (UNK) <u>Vellutini</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara (UNK)</u>		14. NAME OF HUSBAND OR WIFE <u>Bettina Vellutini</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Anna Barsante 5934 Drury Lane</u>					
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) <u>Pulmonary Thrombus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> 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 <u>29 1/2 to 5 1/2</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				444X		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) _____		21d. (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <u>4/31, 1951</u> , to <u>5/5, 1951</u> , that I last saw the deceased alive on <u>5/4, 1951</u> , and that death occurred at <u>9-159m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>John P. Ferrara MD</u> (Degree or title)				23b. ADDRESS <u>7307 Natural Bldg.</u>			23c. DATE SIGNED <u>5/6/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/7/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>4/6/51</u>		REGISTRAR'S SIGNATURE <u>Robert P. Tomke MD</u>		FUNERAL DIRECTOR'S SIGNATURE <u>P. Miceli & Sons</u>		ADDRESS <u>1150N. Kingshighway</u>			

(Licensed Embalmer's Statement on Reverse Side)

State of _____
 Department of Health
 Bureau of Health Services
 License No. _____
 Name of Deceased _____
 Date of Death _____
 Place of Death _____
 Initials of Embalmer _____
 Date of Embalming _____
 Name of Embalmer _____
 License No. _____

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Anthony J. Miceli*

Licensed Embalmer No. 4777

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.

Embalmer's Signature _____