

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 12 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2703**

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) 2 day	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 625a Biddle Street	

3. NAME OF DECEASED (Type or Print) a. (First) Anthony b. (Middle) c. (Last) Tocco		4. DATE OF DEATH (Month) (Day) (Year) March 20th, 1952			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb 19, 1893		
9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit Merchant		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and State or Foreign Country) Italy 5		12. CITIZEN OF WHAT COUNTRY? Italy

13a. FATHER'S NAME Leonardo Tocco	13b. MOTHER'S MAIDEN NAME Rose Orlando	14. NAME OF HUSBAND OR WIFE Sarah Tocco	
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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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph Tocco 5450A ST. LOUIS AVE	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) syphilitic aortitis DUE TO (c) Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 4-6 yrs ??? 2 hrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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? 0 22X

22. I hereby certify that I attended the deceased from **Jan 10, 1952**, to **Mar 20, 1952**, that I last saw the deceased alive on **Mar 20, 1952**, and that death occurred at **10:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. J. Verda M.D.	23b. ADDRESS 4500 Olive	23c. DATE SIGNED 3-21-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-24-52	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. MAR 22 1952	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Benick-Pulaver 1431 Union Bl.
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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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

W. W. Wilkinson

Licensed Embalmer No.

3575

P. O. Address

St. Louis, Mo.

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.