

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14857

State File No.

FILED APR 25 1952

318

1003

3359

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 _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO
c. LENGTH OF STAY (in this place) 2 DAYS
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2169

d. FULL NAME OF HOSPITAL OR INSTITUTION MARION HOSPITAL
d. STREET ADDRESS (If rural, give location) 16 3459 1 PESTALOZZI

3. NAME OF DECEASED (Type or Print)
a. (First) DOMENICO b. (Middle) TORRILLO c. (Last) _____
4. DATE OF DEATH (Month) (Day) (Year) APRIL 8 1952

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH SEPT. 5 1878 9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 6 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAY LABORER 10b. KIND OF BUSINESS OR INDUSTRY RETIRED 11. BIRTHPLACE (State or foreign country) ITALY 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME ANGELO TORRILLO 13b. MOTHER'S MAIDEN NAME KATHERINE GAGLORDI 14. NAME OF HUSBAND OR WIFE LOUISE TORRILLO

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. 492-20-9991 17. INFORMANT'S SIGNATURE OR NAME ADDRESS LOUISE TORRILLO 3459-PESTALOZZI

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) interclumping
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) _____
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
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 NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? H10X

22. I hereby certify that I attended the deceased from Jan 1852, to Apr 8 1952, that I last saw the deceased alive on Apr 8 1952 and that death occurred at 3:02 p.m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) _____ 23b. ADDRESS 2752 4th chmber 23c. DATE SIGNED 4-8-52

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE _____ 24c. NAME OF CEMETERY OR CREMATORY RESURRECTION 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REG. APR 10 1952 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Morris

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

Signed _____

Licensed Embalmer No. 3989

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.