

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19679

State File No. 4902

FILED JUN 1-1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 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 OR TOWN St. Louis, Missouri		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 2109 3629 LEE AVENUE	
3. NAME OF DECEASED (Type or Print) SALVATORE		4. DATE OF DEATH (Month) (Day) (Year) MAY 14, 1953	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH SEPTEMBER 15, 1877 '75	
9. AGE (In years last birthday) 5		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED RESTURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTURANT	
11. BIRTHPLACE (City and State or Foreign Country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOSEPH		13b. MOTHER'S MAIDEN NAME THERESA ROTA	
14. NAME OF HUSBAND OR WIFE CECELIA MASTROIANNI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME CECELIA MASTROIANNI		ADDRESS 3629 LEE AVENUE	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction with subparation of caecum secondary to carcinoma of spleen DUE TO (b) flexure of large intestine 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 <input type="checkbox"/> NO <input checked="" 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 153X			
22. I hereby certify that I attended the deceased from 5-12-53 , 19___, to 5-14-53 , 19___, that I last saw the deceased alive on 5-14-53 , 19___, and that death occurred at 1:05A m., from the causes and on the date stated above.			
23a. SIGNATURE Dorothy Barber M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 5-14-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAY 18, 1953	
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI	
DATE REC'D BY LOCAL REG. MAY 14 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Stock Mortuary		ADDRESS 2117 E. GRAND	

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.....
Signature of Student Embalmer

Signed *Frank C. Jones*.....

Licensed Embalmer No. *304*.....

P. O. Address *2117 E 8*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.