

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 24 1953

State File No. **22997**  
Registrar's No. **5729**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b><br>b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>                                   |  |
| c. LENGTH OF STAY (in this place)<br><b>14 Days</b>                                      |  | d. STREET ADDRESS (If rural, give location)<br><b>1815 Cambridge Lane</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Lutheran</b>                               |  |  |  |

|  |                                  |  |  |  |   |
|--|----------------------------------|--|--|--|---|
| 3. NAME OF DECEASED<br>(Type or Print)<br><b>Angelina</b>  |                                  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>June 7 1953</b> |  |   |
| a. (First)   | b. (Middle)                      |  | c. (Last)<br><b>Loiacono</b>                                   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>Aug. 20 1880</b>                        |  | 9. AGE (In years last birthday) Months Days Hours Mts.<br><b>72</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Home Maker</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at Home</b>                      |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Italy</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |  |  |  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME<br><b>Philip Di Falco</b> |  | 13b. MOTHER'S MAIDEN NAME<br><b>Josephine U. K.</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Dominick Loiacono</b> |  |
|--|--|---|--|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Jasper Loiacono 1815 Cambridge La</b> |  |  |  |
|---|--|---|--|--|--|

|   |  |  |  |  |                                  |
|---|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Intestinal Obstruction</b><br>ANTECEDENT CAUSES<br><b>Acute Shock.</b><br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>Shock.</b>   |  |  |                                  |

|                        |  |                                  |  |   |  |
|------------------------|--|----------------------------------|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  | 20. AUTOPSY?<br>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) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>5705</b>       |  |

22. I hereby certify that I attended the deceased from **June 6, 1953** to **June 7, 1953** that I last saw the deceased alive on **June 7, 1953**, and that death occurred at **2:15 P.M.** from the causes and on the date stated above.

|  |  |  |  |                                   |  |
|--|--|--|--|-----------------------------------|--|
| 23a. SIGNATURE (Degree or title)<br><b>A. J. Plog M.D.</b> |  | 23b. ADDRESS<br><b>3150 Morganford</b> |  | 23c. DATE SIGNED<br><b>6/8/53</b> |  |
|--|--|--|--|-----------------------------------|--|

|  |                             |  |  |
|--|-----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24b. DATE<br><b>6 10 53</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary</b> | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis Mo</b> |
|--|-----------------------------|--|--|

|   |  |   |
|---|--|---|
| DATE REC'D BY LOCAL REG.<br><b>JUN 9 1953</b> | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Walter Kelly 7267 Mid Bridge</b> |
|---|--|---|

(Licensed Embalmer's Statement on Reverse Side)

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

*James A. Lamm*

Licensed Embalmer No.

4142

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.