

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26355**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6372**

46549
FILED JUL 31 1953

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.		e. LENGTH OF STAY (In this place)	
3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) Frienza c. (Last)		4. DATE OF DEATH (Month) June (Day) 25 (Year) 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH June 24, 1953
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	9b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Joseph Frienza		13b. MOTHER'S MAIDEN NAME Rosaria Zuccarello	
14. NAME OF HUSBAND OR WIFE *****		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. *****		17. INFORMANT'S SIGNATURE OR NAME Joseph Frienza ADDRESS 2209 Mullanphy	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth (7 mo gestation) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 type="checkbox"/>		21a. ACCIDENT (Specify) SUICIDE HOMICIDE	
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? 776X		22. I hereby certify that I attended the deceased from 6/24, 1953 , to 6-25, 1953 , that I last saw the deceased alive on 6/23, 1953 , and that death occurred at 6⁰⁰ p.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Joseph B. Guccione M.D.		23b. ADDRESS 2801 N. Taylor	
23c. DATE SIGNED 6/26/53		24a. BURYAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE June 26, 1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P. Miceli 1150 N. Kingshighway	
DATE REC'D BY LOCAL REG. JUN 26 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D. mds (Licensed Embalmer's Statement on Reverse Side)	

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 *Not Embalmed*.....

Licensed Embalmer No. *PA*

P. O. Address *1150 No. 12*

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.