

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26376**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6077**

FILED JUL 31 1953
BIRTH NO. **38986**

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 Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) Missouri		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) 8712 Park Lane		d. STREET ADDRESS (If rural, give location) St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital			d. STREET ADDRESS (If rural, give location) St. Louis		
3. NAME OF DECEASED (Type or Print) a. (First) Gaspere b. (Middle) c. (Last) Giardina			4. DATE OF DEATH (Month) (Day) (Year) 6 16 53		
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6-16-53		9. AGE (In years last birthday) 42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13a. FATHER'S NAME John Carma Giardina		13b. MOTHER'S MAIDEN NAME Badalamenti		14. NAME OF HUSBAND OR WIFE none	
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 John Giardina, 8712 Park Lane, St. Louis, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atalectasis			INTERVAL BETWEEN ONSET AND DEATH 3 hrs		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES		
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 Difficult prolonged labor - instrumental delivery					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7610		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?	
22. I hereby certify that I attended the deceased from June 16, 1953 , to June 16, 1953 , that I last saw the deceased alive on June 16, 1953 , and that death occurred at 7 m. from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Edward H. Snyder, M.D.			23b. ADDRESS 705 - Olive St.		23c. DATE SIGNED 6-17-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-19-1953	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. JUN 18 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bensiek-Niehaus, 1431 N. Union	

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.....

P. O. Address.....

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.