

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41301

FILED DEC 4-1953

1003

11139

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		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 <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>2-WKS.</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				STREET ADDRESS (If rural, give location) <u>4036 Laclede Ave. 2189</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Christine</u> b. (Middle) _____ c. (Last) <u>Vaccaro</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22, 1953</u>						
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>	8. DATE OF BIRTH <u>May 17, 1877</u>		9. AGE (In years last birthday) <u>76</u>	# UNDER 1 YEAR Months <u>6</u>	# UNDER 1 HR. Hours <u>5</u> Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Antone Casaleggi</u>			13b. MOTHER'S MAIDEN NAME <u>Domenico Travasconi</u>		14. NAME OF HUSBAND OR WIFE <u>John Vaccaro</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Leonida Massa, 4036 Laclede Ave.</u>					
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) <u>Carcinoma of gall bladder</u> 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.				INTERVAL BETWEEN ONSET AND DEATH <u>Oct. 1, 1953</u>	
19a. DATE OF OPERATION <u>11/16/53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of gall bladder with metastatic cancer</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		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? <u>155X</u>					
22. I hereby certify that I attended the deceased from <u>10-1</u> , 19 <u>53</u> , to <u>Nov. 22</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>53</u> , and that death occurred at <u>9:45 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Bernard T. Koon M.D.</u>				23b. ADDRESS <u>4755 Maryland Road St. Louis, Mo.</u>		23c. DATE SIGNED <u>11/23/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. , 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>				
DATE RECD BY LOCAL REG. <u>NOV 24 1953</u>		REGISTRAR'S SIGNATURE <u>Arthur J. Donnelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>3840 Lindell Blvd.</u>					

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 *Francis Williamson*.....

Licensed Embalmer No. *3565*.....

P. O. Address *St. Louis?*.....

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.