

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

13215

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

3098

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>ST. LOUIS, MISSOURI</u>)		c. CITY OR TOWN <u>Valier</u>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>8120 S</u>	
3. NAME OF DECEASED a. (First) <u>THERESA</u> (Type or Print)		b. (Middle) <u>(NMI)</u>	
c. (Last) <u>BOZZARDI</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 3, 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-28-1882</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours 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>Italy</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND/OR WIFE <u>Joe</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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Joe Bozzardi Detroit Mich</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATE I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hepatic coma</u> INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Portal cirrhosis</u> 4 mos. 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 checked="" type="checkbox"/> NO <input 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) <u>581.0</u>			
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?			
22. I hereby certify that I attended the deceased from <u>3-29-</u> , 19 <u>54</u> , to <u>4-3-</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>4-3-</u> , 19 <u>54</u> and that death occurred at <u>6:40A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>C. J. Vermillion, M.D.</u>		23b. ADDRESS <u>BARNES HOSPITAL</u>	
23c. DATE SIGNED <u>4-3-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-3-54</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Harrison Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Valier Ill</u>	
DATE REC'D BY LOCAL REG. <u>APR 6 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Union Funeral Home</u>		ADDRESS <u>Christopher St</u>	

(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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.