

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35977**
 BIRTH NO. **7452954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9286**

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 or TOWN St. Louis)		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 24 3309a Salena St.
d. FULL NAME OF HOSPITAL OR INSTITUTION 3309a Salena St.			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) JOHN	b. (Middle) LEE	c. (Last) SIMINO	Oct. 12, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Sept. 30, 1954	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months
				12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Robert Simino		13b. MOTHER'S MAIDEN NAME Mary Cedeck	14. NAME OF HUSBAND OR WIFE NONE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Simino 3309a Salena St.		
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 CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Interstitial Pneumonitis 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7630			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:47 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE <i>Joseph M. Green</i>		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 10/13/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 13, 1954	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.		
DATE REC'D BY LOCAL REG. OCT 13 1954	REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CHULICK UND. CO. 1722 S. Jefferson			

M. J. B. (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
Student Embalmer

Signed Bert E. Hoffman

Licensed Embalmer No. 4306

P. O. Address St. L.

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

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