

FILED DEC 16 1954

STANDARD CERTIFICATE OF DEATH

426202
State File No. _____
REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10792

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

1. PLACE OF DEATH a. COUNTY St. Louis		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) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		e. STREET ADDRESS (If rural, give location) 5617 Lilian	
3. NAME OF DECEASED (Type or Print) a. (First) Giuseppe b. (Middle) _____ c. (Last) Maltese		4. DATE OF DEATH (Month) (Day) (Year) Nov. 25, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 5, 1889
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Barber	11. BIRTHPLACE (City and State or Foreign Country) Italy 5
12. CITIZEN OF WHAT COUNTRY? Italy		13a. FATHER'S NAME Vincenzo Maltese	
13b. MOTHER'S MAIDEN NAME Antonno Gullo		14. NAME OF HUSBAND OR WIFE Francesca Maltese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 499-34-2432	
17. INFORMANT'S SIGNATURE OR NAME Frances Maltese		ADDRESS 5617 Lilian	
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) Carcinoma of liver	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Polycystic Kidneys	
DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 7 mos	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Congenital	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 1561		22. I hereby certify that I attended the deceased from 10-15-1954 , to 11-25, 1954 , that I last saw the deceased alive on 10-25-54, 19 , and that death occurred at 10:30 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE Charles M. Berard, M.D. (Degree or title)		23b. ADDRESS 112 Olive	
23c. DATE SIGNED 11/26/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Nov 28 1954		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) Brooklyn N.Y.		25. FUNERAL DIRECTOR'S SIGNATURE P. Miceli ADDRESS 1150 No. Kingshughway	

(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 *Elmer R. Padwell*

Licensed Embalmer No. *407*

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.**