

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 13 1955

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3821**

1. PLACE OF DEATH a. COUNTY St. Louis		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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) 5478a Beacon	
d. FULL NAME OF HOSPITAL OR INSTITUTION Old Faith Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Emily b. (Middle) Pendino c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) April 28, 1955		
5. SEX Female	6. COLOR OR RACE White	17. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 17, 1882	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Palermo Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jasper Vaccaro	13b. MOTHER'S MAIDEN NAME Maria (Unknown)	14. NAME OF HUSBAND OR WIFE Anthony Pendino
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Marceno 4922 Thrush Ave

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from Colon Adipathia		2 Days
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Pulmonary Infarcts Arteriosclerotic Heart Disease		1 week 5 yrs.
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) (Min) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from **Jan 10, 1955**, to **April 28, 1955**, that I last saw the deceased alive on **April 27, 1955**, and that death occurred at **7:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Snodgrass M.D.	23b. ADDRESS 3720 Washington St.	23c. DATE SIGNED 4/29/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-30-55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. APR 29 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P. Miceli & Sons 1150 N. Kingshighway
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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
Student Embalmer

Signed.....

Anthony J. Muel

Licensed Embalmer No.

4227

P. O. Address.....

St Louis

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

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