

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31436**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7940**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St/ Louis</b>	c. LENGTH OF STAY (in this place) <b>10 days</b>	c. CITY OR TOWN <b>St. Louis</b>	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 <b>St. Luke's Hospital</b>		STREET ADDRESS (If rural, give location) <b>5455 Delmar Blvd.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Victor</b> b. (Middle) <b>Paul</b> c. (Last) <b>Saitta</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9 8 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2/29/1896</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>	IF UNDER 1 HR. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Frank Saitta</b>	13b. MOTHER'S MAIDEN NAME <b>Bernadette Santora</b>	14. NAME OF HUSBAND OR WIFE <b>Bessie Saitta</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W.W.I</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Bessie Saitta</b>	ADDRESS <b>5455 Delmar Blvd. St. Louis Mo.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute yellow atrophy liver</b>		
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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) <b>580x</b>
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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?
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22. I hereby certify that I attended the deceased from **8/24, 1955** to **9/8, 1955**, that I last saw the deceased alive on **9/8, 1955**, and that death occurred at **8:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Sam F. Beam</b>	(Degree or title)	23b. ADDRESS <b>35 No Central - 5-</b>	23c. DATE SIGNED <b>9/9/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>9/12/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 9 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>M. J. Donnelly</b>	ADDRESS <b>#3840 Lindell Blvd.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Lim Beam  
: Mrs. Pam Tobey  
35 Central

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 *James Williamson*

Licensed Embalmer No. *350*  
P. O. Address *3840 Lind*

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.