

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22299**
Registrar's No. **1322**

FILED JUN 22 1956

BIRTH NO. **42792-56** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **544**

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) OR TOWN Kirkwood		c. LENGTH OF STAY (in this place) 45 min's	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hosp.		STREET ADDRESS (If rural, give location) 4441 Delor Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JOSEPH	b. (Middle) MICHAEL	c. (Last) LICARI	(Month) May	(Day) 30	(Year) 1956

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH May 30, 1956		9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Mins. 6	Secs. 45
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Kirkwood Mo		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Gus T. Lacari		13b. MOTHER'S MAIDEN NAME Justine Carey		14. NAME OF HUSBAND OR WIFE none	
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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) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Gus T. Lacari		ADDRESS 4441 Delor	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atalectasis				4 1/2 min	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Immaturity				5 mo gestation	
		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 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)	
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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?	
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22. I hereby certify that I attended the deceased from **May 30**, 19**56**, to **May 30**, 19**56**, that I last saw the deceased alive on **May 30**, 19**56**, and that death occurred at **5:10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Francis J. Weevil M.D.		23b. ADDRESS 5203 Chippewa St.		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/1/56		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
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DATE REC'D BY LOCAL REG. 5-31-56		REGISTRAR'S SIGNATURE Herbert R. Donheym		25. FUNERAL DIRECTOR'S SIGNATURE Callen Kelly		ADDRESS 7267 Natural Bridge	
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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.. *Not Embalmed.*

Student.....
Signature of Student Embalmer

Signed.....

James A. Lamm

Licensed Embalmer No. *414*

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.