

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39385**
Registrar's No. **9603**

BIRTH NO. **80436-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

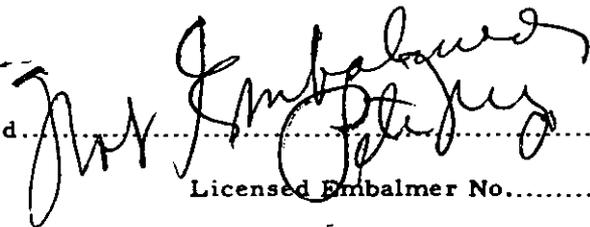
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis 13	
c. LENGTH OF STAY (In this place)		d. 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 De Paul Hospital 906			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) Ann	
c. (Last) Fiorini		4. DATE OF DEATH (Month) (Day) (Year) Oct. 19 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH Oct. 18, 1956
9. AGE (In years last birthday) 28 35		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Frank Joseph FIORINI	
13b. MOTHER'S MAIDEN NAME Gerahline Marie Smith		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Gerahline Marie FIORINI		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Deficiencies e.g. Heart-lip, deep palate, atrophic nasal passage *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. DUPLICATE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUPLICATE TO (c) Single lobe brain; atrophic adrenals, etc. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND 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) 7593	
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?			
22. I hereby certify that I attended the deceased from 10/18, 1956 , to 10/19, 1956 , that I last saw the deceased alive on 10/19, 1956 , and that death occurred at 11:20 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE Roy V. Boedeker MD (Degree or title)		23b. ADDRESS 100 N. Euclid	
23c. DATE SIGNED 10/19/56		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 10-22-56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's ADDRESS 2849 No. Euclid	
DATE REC'D BY LOCAL REG. OCT 22 1956		REGISTRAR'S SIGNATURE J. Carl Smith MO	

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 

Licensed Embalmer No.....

P. O. Address

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.