

Health,
Welfare
Public
Service

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2724
STATE FILE NUMBER

FILED FEB 4 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 567

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN St. Louis Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in lb 20-days	STREET ADDRESS 1633 Alaska Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle Anthony Last Gallo			4. DATE OF DEATH Month Day Year Jan. 16, 1957		
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1890	9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months 2 Days 13 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist Supply Business		10b. KIND OF BUSINESS OR INDUSTRY -Self	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Santo Gallo			14. MOTHER'S MAIDEN NAME Theresa Castringano		
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.	17. INFORMANT Address Mrs. Harriett Brueggeman, 4633 Alaska Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Emphysema DUE TO (c) 527.1					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hrs. 40 Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from Dec. 29, 1956 to Jan. 16, 1957 and last saw her alive on Jan. 16, 1957 Death occurred at 11:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE E. P. Demillion, M.D.		(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/17/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 21, 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	

MEDICAL CERTIFICATION

24. FUNERAL DIRECTOR ADDRESS
Arthur J. Donnelly 3840 Lindell Blvd.

25. DATE RECD. BY LOCAL REG.
JAN 18 '57

26. REGISTRAR'S SIGNATURE
J. Earl Smith, M.D.

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 *Francis Williams*.....

Licensed Embalmer No. *35*

P. O. Address *38407*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.