

Health, Welfare  
Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6386  
STATE FILE NUMBER  
1560

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                           |                                                                                                                                                             |                                                                                                                      |                   |                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                           |                                                                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY |                   |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN ST. LOUIS                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        | c. CITY OR TOWN ST. LOUIS                                                                                            |                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION ST. ANTHONY HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                  |                           | Length of stay in lb<br>2 DAYS                                                                                                                              | d. STREET ADDRESS (If outside, give location)<br>528 W. DAVIS STREET                                                 |                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First JOHN Middle ** Last LA DATO                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                           |                                                                                                                                                             | 4. DATE OF DEATH<br>Month FEBRUARY Day 13, Year 1957                                                                 |                   |                                                                                       |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>JUNE 24, 1887                                                                                    |                   | 9. AGE (In years last birthday)<br>69                                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED                                                                                                                                                                                                                                                                                                                                                                                                                               |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>CITY LIGHTING DEPT.                                                                                                    | 11. BIRTHPLACE (City and state or country)<br>ROCHESTER, NEW YORK                                                    |                   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                |
| 13. FATHER'S NAME<br>AUGUSTUS LA DATO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>FILOMENA SCOTIA                                                                          |                   |                                                                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br>NO NONE                                                                                                                                                                                                                                                                                                                                                                                                             |                           | 16. SOCIAL SECURITY NO.<br>493 05 5345                                                                                                                      | 17. INFORMANT<br>Address LENA LA DATO 528 W. DAVIS STREET                                                            |                   |                                                                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PULMONARY Edema<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ARTERIOSCLEROSIS & Rheumatic Heart Disease<br>DUE TO (c) aortic Insufficiency & Congestive Failure<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Mild Cerebro Vascular Accident |                           |                                                                                                                                                             |                                                                                                                      |                   | INTERVAL BETWEEN ONSET AND DEATH<br>12 HRS.<br>10 yrs.<br>10 yrs.                     |
| 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.)<br>4/6x                                                        |                                                                                                                      |                   |                                                                                       |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                           | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                                                   |                                                                                                                      |                   |                                                                                       |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                               |                           | 20f. CITY, TOWN, OR LOCATION                                                                                                                                |                                                                                                                      | 20g. COUNTY STATE |                                                                                       |
| 21. I attended the deceased from 10/5/56 to 2/13/57 and last saw <sup>her</sup> alive on 2-13-57<br>Death occurred at 4:55 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                                                                                                 |                           |                                                                                                                                                             |                                                                                                                      |                   |                                                                                       |
| 22a. SIGNATURE<br>Charles B. Hall                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                           |                                                                                                                                                             | 22b. ADDRESS<br>7430 Virginia Ave                                                                                    |                   | 22c. DATE SIGNED<br>2-14-57                                                           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | 23b. DATE<br>FEB. 16, 1957                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. OLIVE CEMETERY                                                             |                   | 23d. LOCATION (City, town, or county) (State)<br>LEMAP, MISSOURI                      |
| 24. FUNERAL DIRECTOR<br>C. HOFFMEISTER MORTUARIES<br>7814 SO. BROADWAY ST. LOUIS, MO.                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           |                                                                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br>FEB 15 '57                                                                           |                   | 26. REGISTRAR'S SIGNATURE<br>J. Earl Smith, M.D.                                      |

(Licensed Embalmer's Statement on Reverse Side)

2  
P.M.

**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 *Levin C. Hoffmeister*

Licensed Embalmer No. 38

P. O. Address 7814 S. A.

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.