

FILED MAY 3 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15587

STATE FILE NUMBER

Registration District No. 317Primary Registration District No. 542Registrar's No. 975

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		St. Louis		a. STATE		Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Ferguson		c. CITY OR TOWN		St. Louis	
OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location)		Hilltop House		STREET ADDRESS		5972 Tara Lane	
HOSPITAL OR INSTITUTION		Length of stay in lb		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
37		19 months		5972		Tara Lane	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First		Middle		Last		Month Day Year	
Carmela				Maciocia		4 11 57	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 15, 1882	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?	
74		Home		Italy		U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (City and state or country)			
Housewife				Italy			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Torregrossa				Antoinette unknown			
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 Address			
No		none		Charles Maciocia, 5972 Tara Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH - ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident</u>							19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" 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 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 <u>May 10 - 1956</u> to <u>April 11 - 1957</u> and last saw her <u>her</u> alive on <u>April 11 - 1957</u> . Death occurred at <u>2:00</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
<u>John G. McInerney, M.D.</u>				<u>5014 Thekla Av</u>		<u>4/12/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>4/15/57</u>		<u>Calvary Cemetery</u>		<u>St. Louis Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		
<u>Drehmann-Harral 1905 Union</u>			<u>4-13-57</u>		<u>Neahet K. Dombke</u>		

(Licensed Embalmer's Statement on Reverse Side)

S. 300
v. 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. securing the medical certification in the same manner required by 1937, to move to 1957.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. John G. McSwiney
5014 Thekla
Ev. 5-4688

About 10:30 Fri.

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 *Warren A. Carver*

Licensed Embalmer No. 352

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.