

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

State File No. **18982**  
Registrar's No. **4640**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4640</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6056 Shulte</b>				e. STREET ADDRESS (If rural, give location) <b>6056 Shulte Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>August</b>		a. (First)		b. (Middle)		c. (Last) <b>Lombardo</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>May 14 1957</b>		5. SEX <input type="radio"/> male <input type="radio"/> female		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	
8. DATE OF BIRTH <b>Aug. 1 1892</b>		9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurent</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>August Lombardo</b>		13b. MOTHER'S MAIDEN NAME <b>A. Copini</b>		14. NAME OF HUSBAND OR WIFE <b>Vera Lombardo</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>488 09 6292</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Vera Lombardo 6056 Shulte Ave.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Larynx.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>161x</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		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 <b>Feb 1949</b> , to <b>May 14, 1957</b> , that I last saw the deceased alive on <b>May 14, 1957</b> , and that death occurred at <b>7:30 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Carl Smith MD</b> (Degree or title)				23b. ADDRESS <b>3700 N Grand</b>		23c. DATE SIGNED <b>5/14/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>5/17/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>	
DATE REC'D BY LOCAL REG. <b>MAY 16 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Buchholz Mortuary 5967W. Florissant</b>			

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

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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..

Student.....  
Signature of Student Embalmer

Signed *Wilfred S. Buckhorn*.....

Licensed Embalmer No. *453*.....

P. O. Address *A. Lane*.....

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.