

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26745

STATE FILE NUMBER

FILED JUL 22 1957

Registration District No. 312 Primary Registration District No. 531 Registrar's No. 1765

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>University City 4/3560</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Res. 6815 Roberts</u>			Length of stay in lb <u>5yrs</u>	d. STREET ADDRESS <u>6815 Roberts</u>			(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Rosa</u> First <u>Prelli</u> Middle <u>Prelli</u> Last				4. DATE OF DEATH <u>Sat July 13, 1957</u> Month <u>July</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1901</u>		9. AGE (In years last birthday) <u>55yrs</u> IF UNDER 1 YEAR: Months <u>5</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress Genovese</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pants Factory</u>	11. BIRTHPLACE (City and state or country) <u>Prelo, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archangelo Prelli</u>				14. MOTHER'S MAIDEN NAME <u>*****</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT Address <u>Mr. Bruno Prelli 6815 Roberts Ave</u>			
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>Cacinoma of Pancrease</u> DUE TO (b) <u>Wide Abdominal Metastasis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u> <u>3 mos.</u>	
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 <u>4-25-57</u> to <u>6-5-57</u> and last saw <u>her</u> alive on <u>5-5-57</u> Death occurred at <u>7-13-57</u> <u>6:30</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert H. Sund. MD</u> (Death of title)				22b. ADDRESS <u>1105 Central, Clayton</u>		22c. DATE SIGNED <u>7-13-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 15, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Catholic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Stamford, Conn.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Alexander and Sons - Delmar 6175</u>			25. DATE RECD. BY LOCAL REG. <u>7/14/57</u>		26. REGISTRAR'S SIGNATURE <u>Hubert R. Dombek MD</u>		

(Licensed Embalmer's Statement on Reverse Side)

Dr.

Dr Robt H. Lund
Barns Hospital

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *27*

P. O. Address *617520*

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.