

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1957

37115

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9864

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		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. LOUIS</i>		c. CITY OR TOWN <i>St. LOUIS</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1438 E COLLEGE</i>		Length of stay in lb <i>29</i> STREET ADDRESS <i>1438A E COLLEGE</i> (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <i>CATHERINE</i> Middle Last <i>ALETO</i>		4. DATE OF DEATH Month <i>OCT</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JAN 22, 1902</i>
9. AGE (In years last birthday) <i>55</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NURSE'S AID</i>	11. BIRTHPLACE (City and state or country) <i>St. LOUIS, Mo.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>DAVID BRIZZOLARA</i>	
14. MOTHER'S MAIDEN NAME <i>AMELIA ROSASCO</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>490-03-9828</i>		17. INFORMANT Address <i>DAVID R. ALETO 117 IVY CT.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PLEURAL EFFUSION METASTATIC CANCER (PLEURAL) FROM ADENOCARCINOMA OF OVARIES</i> DUE TO (b) <i>ADENOCARCINOMA OF OVARIES</i> DUE TO (c) <i>ADENOCARCINOMA OF OVARIES</i> 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(n) <i>NONE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 DAYS</i> <i>6 MONTHS</i> <i>6 MONTHS</i>
19. WAS AUTOPSY PERFORMED? 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.) <i>175x</i>		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 <i>16 JUL 57</i> to <i>20 OCT 57</i> and last saw <sup>(had him)</sup> alive on <i>11 OCT 57</i> Death occurred at <i>IA</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>James F. Michael M.D.</i> (Degree or title)		22b. ADDRESS <i>4952 MARYLAND ST. ST. LOUIS 8, MO.</i>	
22c. DATE SIGNED <i>21 OCT 57</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
23b. DATE <i>10/23/57</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEMETERY</i>	
23d. LOCATION (City, town, or county) <i>St. LOUIS, Mo.</i>		(State)	
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</i>		25. DATE RECD. BY LOCAL REG. <i>OCT 22 57</i>	
26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i>			

**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 *E. P. Kidwell*.....

Licensed Embalmer No. *387*.....

P. O. Address *7037*.....

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.