

pt. Health,  
c. & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38676  
STATE FILE NUMBER  
Registrar's No. 2573

FILED NOV 15 1957

Registration District No. 317 Primary Registration District No. 500

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bellefontaine Neighbors</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY <b>4000</b> OR TOWN <b>Bellefontaine Neighbors</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>10662 Coburg Lands 4 YEARS</b> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>1) 10662 Coburg Lands</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle Last <b>Alagna</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>17</b> Year <b>1957</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11 1953</b>	9. AGE (In years lost <sup>1</sup> / <sub>4</sub> day)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Rocco Joseph Alagna</b>	13b. MOTHER'S MAIDEN NAME <b>Theresa Lee Diratta</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT Address <b>Rocco Alagna 10062 Coburg Lands</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Since Birth</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Osteogenesis Imperfecta</b>	
	DUE TO (c) <b>758.3</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>7/12/53</b> to <b>12/11/56</b> and last saw her alive on <b>12/11/56</b> Death occurred at <b>10:00 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Samuel W Gollobm D.</b>	22b. ADDRESS <b>8112 Delmar</b>	22c. DATE SIGNED <b>Oct 18 1957</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 19, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Miceli 1150.No. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>10-18-57</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke MD</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Elmer R. Padwick* .....

Licensed Embalmer No. *4077*  
P. O. Address *St. Louis*

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.