

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

96026-57

46210

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registration District No.

10325

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN CLAYTON		4462 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePAUL HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 27 6340 SOUTHWOOD		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last MARIA PICCIONE			4. DATE OF DEATH Month Day Year OCT. 31, 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31, 1957	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Mins 13 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME PETER PICCIONE			14. MOTHER'S MAIDEN NAME NANCY ANN HOLMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address PETER PICCIONE 6340 SOUTHWOOD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth 6 1/2 mos Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atelectasis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH	
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? 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 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 10-31-57, to 10-31-57 and last saw her alive on 10-31-57 Death occurred at 11:20 p m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree, or title) L. L. Lantieri M.D.			22b. ADDRESS 7801 N. Taylor		22c. DATE SIGNED 11-1-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV. 2, 1957	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) - (State) ST. LOUIS, MISSOURI		
24. FUNERAL DIRECTOR ADDRESS STROOT CARROLL 1600 NATURAL BRIDGE		25. DATE RECD. BY LOCAL REG. NOV 2 1957	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

(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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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