

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2879  
STATE FILE NUMBER  
1101

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300  
1-57

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

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, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Length of stay in 1b		d. STREET ADDRESS <b>6828 Hancock Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMIL A. FILIPPINE</b>				4. DATE OF DEATH <b>JANUARY 28, 1958</b> Month Day Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26, 1899</b>		9. AGE (In years last birthday) <b>38</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Driver-Bailey Farm Dairy Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Angelo Filippine</b>			13b. MOTHER'S MAIDEN NAME <b>Augusta Pedrolie</b>			14. NAME OF HUSBAND OR WIFE <b>Caroline Filippine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>489-03-9497</b>		17. INFORMANT Address <b>Caroline Filippine 6828 Hancock Ave</b>				
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>HODGKIN'S DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<b>201X</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? YES <input checked="" 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.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK 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 <b>JAN. 14, 1958</b> to <b>JAN. 28, 1958</b> and last saw her alive on <b>JAN. 28, 1958</b> Death occurred at <b>5:45 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>C. P. Vermillion, M.D.</i> (Degree or title)					22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>1/28/58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 31, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>			23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b> (State)			
24. FUNERAL DIRECTOR <b>Kriegshausler 4228 S.Kingshighway</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>JAN 29 '58</b>		26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</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 *William B White* .....

Licensed Embalmer No. *291* .....

P. O. Address *2280 ...* .....

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.