

Health,
Welfare
Public
Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2909

STATE FILE NUMBER

FILED JAN 13 1958

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 36

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Fragale		4. DATE OF DEATH January 1, 1958	
First Middle Last		Month Day Year	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 11, 1889	
9. AGE (In years birthday) 68		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Vincent Fragale		13b. MOTHER'S MAIDEN NAME Florence Unknown	
14. NAME OF HUSBAND OR WIFE Rosalie			
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 Rosalie Fragale, 5124 Shaw Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 12/31/57 6pm to 1/1/58 and last saw him alive on 1/1/58 Death occurred at 8:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul M. Larson, M.D. (Degree or title)		22b. ADDRESS	
22c. DATE SIGNED JAN 3 '58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-4-58	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Calcaterra Funeral Home, 5140 Daggett		25. DATE RECD. BY LOCAL REG. JAN 3 '58	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		No. J. 13.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Robert M. Murray
3749

Licensed Embalmer No.
P. O. Address St. Louis Mo

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.