

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016224
STATE FILE NUMBER 3920

FILED APR 18 1958

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

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5537 Devonshire Ave		d. STREET ADDRESS 5537 Devonshire Ave	

3. NAME OF DECEASED (Type or print) First Middle Last Joseph Munaco			4. DATE OF DEATH Month Day Year April 5, 1958		
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5. SEX Male 0	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 July 27, 1888	9. AGE (In years (If under 1 year, give month and day) (If under 24 hrs., give hours and minutes) 89
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10a. USUAL OCCUPATION (Give kind of work done) Construction work	10b. KIND OF BUSINESS OR INDUSTRY Retired 20 Years	11. BIRTHPLACE (City and state or country) Italy 5	12. CITIZEN OF WHAT COUNTRY? Italy
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13a. FATHER'S NAME Alphonse Munaco	13b. MOTHER'S MAIDEN NAME Margaret	14. NAME OF HUSBAND OR WIFE Ina Munaco
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. 498-10-8793a	17. INFORMANT Ina Munaco 5537 Devonshire Ave
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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) O.K. <i>Chronic Benetititis with acute cardiac failure</i> <i>Chronic myocarditis</i> O.K. <i>Chronic myocarditis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH years 48 hrs of 54
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20a. ACCIDENT / SUICIDE / HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>huc</i>
20c. TIME OF INJURY Hour Month, Day, Year a.m. <i>huc</i>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
21a. Attended the deceased from Death occurred at 9:45 A.M. to 4-4-58 4-5-58 and last saw him alive on 4-5-58		

22a. SIGNATURE <i>D. C. P. P. M. D.</i>	22b. ADDRESS 4523 S. Hughes	22c. DATE SIGNED 4/7/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-9-58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo
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24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. APR 8 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, tubercle, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr.C.O.Pfeiffer

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 *Richard W. Storer*

Licensed Embalmer No. *4007*

P. O. Address

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.