

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030723

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7734

FILED AUG 28 1958

5. 300
1-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis,</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Johns Hosp.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>5338 Tamm Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle Last <u>MAGNANO</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>7,</u> Year <u>1958</u>	
--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1895</u>	9. AGE (In years last birthday) <u>62</u>	10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	-----------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer-Retd</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>Italy-Naturized</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	--	---

13a. FATHER'S NAME <u>Gaetano Magnano</u>	13b. MOTHER'S MAIDEN NAME <u>Carmela Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Theresa Magnano</u>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>552-14-9352</u>	17. INFORMANT Address <u>Theresa Magnano-5338 Tamm Ave.</u>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Rheumatic Valvular Heart Disease (Aortic Stenosis Mitral Stenosis)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>410x</u>		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 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 <u>3-8-49</u> to <u>8-7-58</u> and last saw <u>him</u> alive on <u>8-7-58</u> Death occurred at <u>1:00 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles Montani M.D.</u>	22b. ADDRESS <u>5147 Daggott Ave.</u>	22c. DATE SIGNED <u>8-8-58</u>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-11-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser-4228 S. Kingshighway</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 9 '58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	--	---

(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 *William B. White*

Licensed Embalmer No. *4281*

P. O. Address *42nd St. New York*

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.