

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034490

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

9146

FILED OCT 3 1958

S. 300  
1-57

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, Missouri		c. CITY OR TOWN St. Louis,	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 HOSPITAL OR 2629 N. Spring Ave.		d. STREET ADDRESS (If outside, give location) 2629 N. Spring Ave.	
Length of stay in 1b R119		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vito Marino			4. DATE OF DEATH Month Day Year September 20, 1958
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 July 22, abt 1883
9. AGE (In years) abt 75		FUNDED YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delicatessen Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Groceries	11. BIRTHPLACE (City and state or country) Italy
12. CITIZEN OF WHAT COUNTRY? Italy		13a. FATHER'S NAME Vincenzo Marino	
13b. MOTHER'S MAIDEN NAME Cosimo Taffa		14. NAME OF HUSBAND OR WIFE Josephine Marino	
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. —	17. INFORMANT Address Josephine Marino 2629 N. Spring Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Internal Hemorrhage following gunshot wound of the chest.</i> DUE TO (b) <i>E981X</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If any, state them in full, including the name of the disease, condition, or injury) <i>shot under chest with hands of parties unknown to the doctor at 2629 N. Spring Ave. about 9:35 p.m.</i>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II, if known) <i>shot under chest with hands of parties unknown to the doctor at 2629 N. Spring Ave. about 9:35 p.m.</i>		
20c. TIME OF INJURY Hour Month, Day, Year 9:35 p.m. September 20 1958.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Store</i>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St. Louis Mo</i>		
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <i>9:50 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write in ink) <i>Patrick J. Taylor Carmel</i>		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>9.23.58.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>September 24, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
24. FUNERAL DIRECTOR <i>Bonnie Nichols</i>	ADDRESS <i>1431 Union Blvd.</i>	25. DATE RECD. BY LOCAL REG. <i>SEP 23 1958</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i> <i>mjb.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *John J. Haines* .....

Licensed Embalmer No. *4108* .....

P. O. Address *J. Haines* .....

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.