

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037954  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9484

**FILED OCT 17 1958**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
38 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>100 N. Euclid</u>		Length of stay in lb <u>19</u> d. STREET ADDRESS (If outside, give location) <u>4163 Maryland</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>LaPresto</u> Last <u>LaPresto</u>			4. DATE OF DEATH Month <u>October</u> Day <u>2nd</u> Year <u>1958</u>		
5. SEX <u>M.</u> <u>O.</u> <u>W.</u>	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1878</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Furniture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Used Furniture</u>		11. BIRTHPLACE (City and state or country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Frank LaPresto</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Ciresi</u>	
14. NAME OF HUSBAND OR WIFE <u>Margarita LaPresto</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>no</u>	
17. INFORMANT <u>Margarita LaPresto</u>		Address <u>5733 McPherson</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>Gunshot wound of head</u>			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>E976x</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Self inflicted in room</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DECEASED HOW INJURY OCCURRED (Give nature of injury in PART I or PART II of item 18.) <u>Shot at 100 North Euclid Ave about 10:20 am, October 2nd</u>			
20c. TIME OF INJURY Hour <u>10:20</u> a.m. Month, Day, Year <u>10 2 58 '58</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, office, factory, street, automobile, etc.) <u>Office City</u>		20f. CITY OR TOWN, OR LOCATION <u>St. Louis</u> COUNTY <u>Mo.</u> STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>1027A</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Joseph J. Donnelly</u> (Degree or title) <u>3</u>		22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>10/3/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>10-4-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis</u>		23e. STATE <u>Missouri</u>			

24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u> ADDRESS <u>3840 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 3 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>acm</u>	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

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 \_\_\_\_\_

Licensed Embalmer No. 4699

P. O. Address 3840 Linden

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.