

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042548

STATE FILE NUMBER

FILED NOV 17 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2932

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1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>ST LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Overland 424X</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS CO Hosp</u>		Length of stay in lb <u>3 wk</u>	d. STREET ADDRESS (If outside, give location) <u>2322 Wengler</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Manzella</u> Last <u>Manzella</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>4.</u> Year <u>1958</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</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>2-23-1885</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>26</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</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>CHARLES BONMARITO</u>		13b. MOTHER'S MAIDEN NAME <u>FILOMINA RUSSO</u>		14. NAME OF HUSBAND OR WIFE <u>VITO MANZELLA</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>NONE</u>	17. INFORMANT <u>Rena Orlando Overland Mo</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>Cerebrovascular accident Suspected</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis + MS HD</u>					
DUE TO (c) <u>Diabetes mellitus - 260X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post-op non-healing of amputated left leg.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>10:15</u> Month, Day, Year <u>10-14-58</u> a.m. - p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>10-14-58</u> to <u>11-4-58</u> and last saw her <u>him</u> alive on <u>11-4-58</u> Death occurred at <u>10:15</u> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert M. Lay M.D.</u>			22b. ADDRESS <u>601 S. Brentwood Clayton</u>		22c. DATE SIGNED <u>11/5/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11-7-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
24. FUNERAL DIRECTOR <u>ORTMANN F Home</u>		ADDRESS <u>Overland Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-5-58</u>	26. REGISTRAR'S SIGNATURE <u>Robert C. Donke M.D.</u>

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 *Al C. Ostmann* .....

Licensed Embalmer No. *3478* .....

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.