

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042880

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2821

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b><br>b. COUNTY                                      |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Carsonville</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>37 Penn Nursing Home</b>  |  | Length of stay in lb<br><b>1 mo</b>   | d. STREET ADDRESS (If outside, give location)<br><b>2180 4392a Gibson</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Casimira</b> Middle <b>Cullia</b> Last <b>Quattuccio</b>  |  |   | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>1</b> Year <b>58</b>   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Wh</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 5 1880</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Seamstress</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mens Clothing</b>   | 9. AGE (In years - last birthday)<br><b>78</b><br>IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 11. BIRTHPLACE (City and state or country)<br><b>Italy</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>  |   |
| 13a. FATHER'S NAME<br><b>Alfonso Cullia</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Mary unk</b>  | 14. NAME OF HUSBAND OR WIFE<br><b>Salvatore</b>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>492-07-1724A</b>  | 17. INFORMANT<br><b>Manuel Quattuccio</b><br>Address <b>Moore 3422 St Thomas</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Pancreas</b>   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>157x</b>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>1) Old Cerebral thrombosis, 2) Arteriosclerosis</b>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ o.m. _____ p.m.   |  |   |   |
| 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, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE  |   |
| 21. I attended the deceased from <b>Oct 5, 1958</b> to <b>Nov 1, 1958</b> and last saw her alive on <b>Oct 30, 1958</b><br>Death occurred at <b>5:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |
| 22a. SIGNATURE<br><b>Lewis Littmann MD</b> (Degree or title)  |  | 22b. ADDRESS<br><b>8231 Clayton Rd (17)</b>   | 22c. DATE SIGNED<br><b>11/3/58</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>11/4/58</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo</b>   |
| 24. FUNERAL DIRECTOR<br><b>Miceli 1150 N. Kingshiway</b>  |  | 25. DATE RECD. BY LOCAL REG.<br><b>11-3-58</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Hubert B. Donk MD</b>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Stanley H. Dixon*

Licensed Embalmer No. *4193*

P. O. Address *H. L.*

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.