Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002976
STATE FILE NUMBER 260

FILED FEB 11 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION Mo.Baptist Hospital — Length of stay in Ib 6 wks.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St.Louis
c. CITY OR TOWN St.Ferdinadn Twp 4036 0 — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) 12912 Spanish Pond Rd. — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First FRANK Middle Last GIUNTA
4. DATE OF DEATH Month Day Year January 7th,1959
5. SEX male 0
6. COLOR OR RACE white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH November 18th,1885
9. AGE (In years last birthday) 73 — IF UNDER 1 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) presser retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Italy 5
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Rocco Giunta
13b. MOTHER'S MAIDEN NAME not known
14. NAME OF HUSBAND OR WIFE Angelina Giunta
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Angelina Giunta, Address 12912 Spanish Pond Rd.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Rectum — 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) 154X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 12/8/58, to 1/7/59 and last saw ~~him~~ him alive on 1/7/59
Death occurred at 11:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. S. Brown (Degree or title) M.D.
22b. ADDRESS 3903 Olive
22c. DATE SIGNED 1/8/59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 1/10/59
23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery
23d. LOCATION (City, town, or county) (State) St.Louis, Mo.

24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, ADDRESS 8319 Hallsferry
25. DATE RECD. BY LOCAL REG. JAN 9 '59
26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be issued. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Shamokin

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.