

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006918

STATE FILE NUMBER

21638

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registration No.

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Faith Hosp		Length of stay in lb 30 yrs	d. STREET ADDRESS (If outside, give location) 2701 Sullivan Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Benedetta Middle Bono Last Bono			4. DATE OF DEATH Month 2 Day 13 Year 59			
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5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1890	9. AGE (In years birthday) 68	IF UNDER 1 YEAR Months 5 Days	IF UNDER 24 HRS. Hours 5 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own house	11. BIRTHPLACE (City and state or country) Italy	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Joseph Leone	13b. MOTHER'S MAIDEN NAME Crucifix Badalanenti	14. NAME OF HUSBAND OR WIFE Pietro
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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. 488-30-65	17. INFORMANT Pietro Bono Address 2701 Sullivan
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b) arteriosclerotic heart disease		
DUE TO (c) Diabetes mellitus		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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.)
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20c. TIME OF INJURY Hour 1 Month, Day, Year 2/13/59 a.m. <input checked="" type="checkbox"/> p.m.

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis, Mo	COUNTY	STATE
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21. I attended the deceased from 2/13/59 to 2/13/59 and last saw her alive on 2/13/59 Death occurred at 10:00 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Max S. Franklin M.D. (Degree or title)	22b. ADDRESS 634 N. Grand Ave.	22c. DATE SIGNED 2/14/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/16/59	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis, Mo
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24. FUNERAL DIRECTOR Miceli 1150 N. Kingshiway	25. DATE RECD. BY LOCAL REG. FEB 16 '59	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.
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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..... *Charles R. Sadwell*

Licensed Embalmer No. *4077*

P. O. Address *St. Louis*

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.