

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007414

STATE FILE NUMBER  
2 1239

FILED FEB 17 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5307 Shaw Ave.</b>		Length of stay in 1b <b>50 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>5307 Shaw Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Marcellini</b> Last			4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1881</b>	9. AGE (In years last birthday) <b>77</b> 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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Italy 5</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>Pietro Calcaterra</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Dominic</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Charles Marcellini, 5307 Shaw Ave.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident - Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	DUE TO (c) <b>generalized arterio-sclerosis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus 9 yrs - 332X</b>			

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 _____ Month, Day, Year _____ a.m. _____ p.m. _____				

20d. INJURY OCCURRED WHILE AT <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 <b>St. Louis, Mo.</b>	COUNTY	STATE
21. I attended the deceased from <b>10-14-49</b> to <b>2-2-59</b> and last saw her alive on <b>2-1-59</b> Death occurred at <b>7:50 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Charles Montani M.D.</b>		22b. ADDRESS <b>5147 Daggett Ave</b>		22c. DATE SIGNED <b>2-3-59</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Calcaterra Funeral Home, 5140 Daggett</b>			25. DATE RECD. BY LOCAL REG. <b>FEB 4 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</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 *Lawrence C. Berling*

Licensed Embalmer No. *4979*  
P. O. Address *St. Louis, Mo.*

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.