

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007415

STATE FILE NUMBER

2-1334

FILED MAR 2 1959 Registration District No. Primary Registration District No. Registrar's No.

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Mo.</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><b>St. Louis</b>                   |  | Inside Limits<br>Yes <input checked="" 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>406 Blase</b> |  | Length of stay in lb  | d. STREET ADDRESS (If outside, give location)<br><b>406 Blase</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Ignazio</b> Middle Last <b>Marino</b> |  |  | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>5</b> Year <b>1959</b> |  |  |
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| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr. 24 1887</b> | 9. AGE (In years last birthday) <b>71</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)<br><b>laborer</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>metal goods</b> | 11. BIRTHPLACE (City and state or country)<br><b>Italy</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |
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| 13a. FATHER'S NAME<br><b>Jake Marino</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Not Known</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Rose Marino</b> |
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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)<br><b>no</b> | 16. SOCIAL SECURITY NO.<br><b>489 20 8764</b> | 17. INFORMANT Address<br><b>Rose Marino 406 Blase Ave.</b> |
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| 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>acute coronary occlusion</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min.</b>   |               |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Pneumonia</b>              |  | <b>1 week</b> |
|  | DUE TO (c) <b>Diabetes mellitus 260X</b> |  | <b>3 yrs.</b> |
| 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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b> |               |

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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<br>Hour Month, Day, Year<br>a.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 COUNTY STATE |
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| 21. I attended the deceased from <b>1-15-56</b> to <b>2-5-59</b> and last saw him alive on <b>2-3-59</b><br>Death occurred at <b>1:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><b>H. W. Enright M.D.</b> | 22b. ADDRESS<br><b>832 W. Broadway</b> | 22c. DATE SIGNED<br><b>2-6-59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> | 23b. DATE<br><b>2/9/59</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> |
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| 24. FUNERAL DIRECTOR<br><b>Buchholz Mortuary 5967 W. Florissant</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 7 - 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Keith M.D.</b> |
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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 *Walter H. Beckley* .....  
Licensed Embalmer No. *4557* .....  
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.