

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007836

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 604

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richmond Hgts. 4485</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hosp.</u>		Length of stay in 1b <u>D. O. A.</u>	d. STREET ADDRESS (If outside, give location) <u>7475 Hoover Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ADOLPH</u> Middle <u></u> Last <u>CARRETTI</u>			4. DATE OF DEATH Month <u>March</u> Day <u>3rd</u> Year <u>1959</u>		
--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>2</u>	8. DATE OF BIRTH <u>Oct. 1st 1881</u>	9. AGE (In years, months, days) <u>77</u> <u>3</u> <u>2</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
-----------------------	----------------------------------	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Wood Carver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	11. BIRTHPLACE (City and state or country) <u>Florence, Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>Vincent Carretti</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Amelia Carretti</u>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	SOCIAL SECURITY NO. <u>488-0579826A</u>	17. INFORMANT <u>Mary Carretti</u>	Address <u>7475 Hoover Ave.</u>
--	---	---------------------------------------	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>coronary artery disease</u>	
	DUE TO (c) <u>Myocardial infarction + hepatitis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? 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 Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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 <u>St. Louis</u>	COUNTY <u></u> STATE <u></u>
---	---	--	--	------------------------------

21. I attended the deceased from <u>Mar 59</u> to <u>2-21-59</u> and last saw him alive on <u>2-21-59</u> Death occurred at <u>5 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <u>M. Kimmelman M.D.</u>	(Degree or title)	22b. ADDRESS <u>1005 Big Bend Ave</u>	22c. DATE SIGNED <u>3-5-59</u>
--	-------------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
--	----------------------------------	--	--

24. FUNERAL DIRECTOR <u>A. H. Bocklage</u>	ADDRESS <u>6536 Clayton Rd.</u>	25. DATE RECD. BY LOCAL REG. <u>3-5-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
---	------------------------------------	---	---

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 *Harvey Kahle* .....

Licensed Embalmer No. *4596* .....

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.