

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010971
STATE FILE NUMBER
2520

MAR 30 1959 Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Mehlville 4000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp.		d. STREET ADDRESS (If outside, give location) RR. #11, Box 690	

3. NAME OF DECEASED (Type or print) Baby Margaret Rose Gualdoni			4. DATE OF DEATH Month Mar. Day 12 Year 1959		
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1959	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Gualdoni	13b. MOTHER'S MAIDEN NAME Roseadle Scarpella	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mehlville, Mo. Chas. Gualdoni RR1, Box 690,
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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) Intra cranial hemorrhage		INTERVAL BETWEEN ONSET AND DEATH at 13:45
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) @ with marked hydrocephalus + spinabifida	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 752x		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.) none
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 3/2/59 to 3/12/59 and last saw her ^{her} _{him} alive on 3/12/59 Death occurred at 1A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm. J. Wolawa MA FRCR (Degree or title)	22b. ADDRESS 3804 Wilmington Ave	22c. DATE SIGNED 3/12/59
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23a. BURIAL, CREMATION, REMOVAL removal	23b. DATE 3-12-59	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.
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24. FUNERAL DIRECTOR Southern Funeral Home 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. MAR 12 '59	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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MA 113

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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-57

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 Was not Embalmed., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Joseph J. Piskulke
Licensed Embalmer No.
P. O. Address

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.