

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019722
STATE FILE NUMBER
2 4487

Health,
Welfare
Public
Service

300
-57

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FILED MAY 18 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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo.		c. CITY OR TOWN St. Louis Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		d. STREET ADDRESS (If outside, give location) 4835 Kossuth ave.	

3. NAME OF DECEASED (Type or print) First FRANK Middle VALENTI Last	4. DATE OF DEATH Month May Day 5 Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1 1889	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of life or in if retired) Grocery	10b. KIND OF BUSINESS OR INDUSTRY Owner	11. BIRTHPLACE (City and state or country) Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Anthony Valenti	13b. MOTHER'S MAIDEN NAME Mary Cipplano	14. NAME OF HUSBAND OR WIFE Patricia Valenti
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Patricia Valenti Address 4835 Kossuth av
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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) acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH (one hour)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arterio-sclerotic cardiac disease		
DUE TO (c) Hypertensive Heart Disease		
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? 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.) 4201
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 COUNTY STATE

21. I attended the deceased from Nov. 29, 1952 , to MAY 5, 1959 and last saw her alive on MAY 5, 1959 Death occurred at 9 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE A. Cipplano M.D. (Degree or title)	22b. ADDRESS 1901 Madam St	22c. DATE SIGNED 5/6/59
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23a. BURIAL, CREMATION, REPLY TO FUNERAL HOME	23b. DATE May 8th 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
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24. FUNERAL DIRECTOR MICELI & SONS ADDRESS 1150 N. Kogshway Blvd	25. DATE RECD. BY LOCAL REG. MAY 7 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard certificate. All diseases in Part I must be causally related.

MIB

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 *Robert M. Murray*

Licensed Embalmer No. *3749*
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.