

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019726
STATE FILE NUMBER
2 4663
Registrar's No.

FILED MAY 26 1959

Registration District No. _____ Primary Registration District No. _____

300
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|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Louis</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> | | Length of stay in lb <u>3 days</u> | | d. STREET ADDRESS <u>6005 Surburban</u> | |
| Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SALVATORE NMN VENTIMIGLIA</u> | | | 4. DATE OF DEATH Month Day Year <u>MAY 11, 1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 15, 1885</u> | 9. AGE (In years less birthday) <u>73</u> | IF UNDER 1 YEAR Months <u>6</u> Days <u>26</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Caulker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Laclede Gas Co.</u> | | 11. BIRTHPLACE (City and state or country) <u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13a. FATHER'S NAME <u>Theodore Ventimiglia</u> | | 13b. MOTHER'S MAIDEN NAME <u>Vita Valenti.</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Rosaria Ventimiglia</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> | | 16. SOCIAL SECURITY NO. <u>492-03-8340</u> | |
| 17. INFORMANT <u>Mrs. Rosaria Ventimiglia</u> | | Address <u>6005 Surburban</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>PULMONARY EDEMA AND ATELECTASIS</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1-2 HOURS</u> |
| DUE TO (b) <u>ACUTE CONGESTIVE HEART FAILURE</u> | | | | | <u>1 DAY</u> |
| DUE TO (c) <u>ARTERIOSCLEROSIS</u> | | | | | <u>SEVERAL YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>EPISTAXIS OF UNDETERMINED ETIOLOGY</u> <u>POST-OPERATIVE ABDOMINAL AORTIC GRAFT FOR ANEURYSM</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 .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 <u>MAY 31, 1956</u> to <u>MAY 11, 1959</u> and last saw her alive on <u>MAY 11, 1959</u> Death occurred at <u>3:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>C. O. Ventimiglia M.D.</u> | | 22b. ADDRESS <u>BARNES HOSPITAL</u> | | 22c. DATE SIGNED <u>5/12/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>May 14, 1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery.</u> | |
| 23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> | | (State) | | | |
| 24. FUNERAL DIRECTOR <u>Bensiek-Niehaus Morticians</u> | | ADDRESS <u>1431 Union St.</u> | | 25. REC'D. BY LOCAL REG. <u>MAY 13 1959</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Earl Smith 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 *Bluno R. Padwell*

Licensed Embalmer No. *4077*
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.