

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026465

FILED VS AUG 3 1959

2 6477

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN Normandy Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | d. STREET ADDRESS (If outside, give location) 3007 Gary Drive., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First FANNIE Middle a-k as CROSSIFISSA Last BUFFA | 4. DATE OF DEATH Month JULY Day 8 Year 1959 |
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|----------------------|-------------------------------|---|-----------------------------------|----------------------------------|--|--|
| 5. SEX Female | 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 7/24/1898 | 9. AGE (last birthday) 60 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|----------------------|-------------------------------|---|-----------------------------------|----------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Italy | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Dominick Sharamitaro | 13b. MOTHER'S MAIDEN NAME Antonina Ventimiglia | 14. NAME OF HUSBAND OR WIFE Tony Buffa |
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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) No | 16. SOCIAL SECURITY NO. Nil | 17. INFORMANT Address Tony Buffa, 3007 Gary Drive., |
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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) COR PULMONALE | INTERVAL BETWEEN ONSET AND DEATH FEW WEEKS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARDIAC INSUFFICIENCY | SEVERAL WKS |
| DUE TO (c) CHRONIC CYSTIC BRONCHIECTASIS | FEW YEARS |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 526x | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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| 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 **MAY 20, 1959** to **JULY 8, 1959** and last saw her alive on **JULY 8, 1959**
Death occurred at **6:00 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) C. C. Vannellia, M.D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 7/9/59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7-10-59 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri. |
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| 24. FUNERAL DIRECTOR ADDRESS Biesiek-Niehaus, 1431 Union Blvd., | 25. DATE RECD. BY LOCAL REG. JUL 9 59 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

John J. Heine

Licensed Embalmer No. 4108

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.