

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 13 1959

59-026475

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7169** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 11 HOURS	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4143 RUSSELL AVENUE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last TOM CAITO AKA Thomas Caito			4. DATE OF DEATH Month Day Year 7/31/59		
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 2/10/93	9. AGE (last birthday) 66	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JOHN CAITO		13b. MOTHER'S MAIDEN NAME ANTONI GALLONE		14. NAME OF HUSBAND OR WIFE JOSEPHINE CAITO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. 494-10-5364	17. INFORMANT Address VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ORTHOSTATIC PNEUMONIA					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) ADENOCARCINOMA OF HEAD OF PANCREAS			1 YEAR
		DUE TO (c) 157X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m. Month, Day, Year					
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	
21. I attended the deceased from 1/25/59 to 7/31/59 and last saw him live on 7/31/59 Death occurred at 1:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE HARRY L. ELLIS (degree or title) M.D.			22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 7/31/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
24. FUNERAL DIRECTOR ADDRESS Bensiek-Niehaus Morticians 1431 Union Blvd.		25. DATE RECD. BY LOCAL REG. AUG 3 '59	26. REGISTRAR'S SIGNATURE Harold Smith, M.D.		

DOCUMENT

DR. ELLIS CLEARED THROUGH CORONERS OFFICE

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

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lawrence O. Gerke

Licensed Embalmer No. 497

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.