

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 11 1959

59-030618

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2. 8036**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 8 days		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 ST. LOUIS CITY HOSP. #1.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3127 Locust			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AUGUSTINE Middle Last MA IO				4. DATE OF DEATH Month AUG. Day 28 Year 1959				
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/20/69	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY own house		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY Italy	
13a. FATHER'S NAME Jasper Accardi			13b. MOTHER'S MAIDEN NAME Agata unk			14. NAME OF HUSBAND OR WIFE Frank		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mary Sciortino 4355 Lee			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatic abscess & Rupt Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Subdiaphragmatic Abscess DUE TO (c) Cholelithiasis & Cholecystitis							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Pulmonary Thrombi					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			
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.) 587.0				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
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 8/25/59 to 8/28/59 and last saw her/him alive on 8/28/59 Death occurred at 12:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) D. David P. [Signature]				22b. ADDRESS 1515 Lafayette Ave.		22c. DATE SIGNED 8/28/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/31/59	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) St. Louis, Mo				
24. FUNERAL DIRECTOR ADDRESS Miceli 1150 N. Kingshiway			25. DATE RECD. BY LOCAL REG. AUG 31 1959		26. REGISTRAR'S SIGNATURE Carl Smith, M.D. mjb			

DEED

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Anthony J. Muel

Licensed Embalmer No. 477

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.