URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-033928

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7816

MENDED

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

Length of stay in 1b

c. CITY OR TOWN Afton.

Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptiste Hospital

Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 9428 Tiber Drive

Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last
Nicola Ioco (AKA Nicola Yocco)

4. DATE OF DEATH Month Day Year
August 23, 1959

5. SEX Male

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH November 15, 1877

9. AGE (last birthday) 81

IF UNDER 1 YEAR: Months 8 Days 8

IF UNDER 24 HR: 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 Lamp Lighter

11. BIRTHPLACE (City and state or country) Italy

12. CITIZEN OF WHAT COUNTRY Italy

13a. FATHER'S NAME Giacolina Ioco

13b. MOTHER'S MAIDEN NAME Albina Unknown

14. NAME OF HUSBAND OR WIFE deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address
Mrs. Sam Garofalo. 9428 Tiber Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cerebral thrombosis with left hemiplegia — 1 wk.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis — "

DUE TO (c) 332X

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 16 Aug 59, to 23 Aug 59 and last saw her/him alive on 23 Aug 59

Death occurred at 1 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Richard A. Jones MD

22b. ADDRESS 3720 Washington

22c. DATE SIGNED 24 Aug 59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE August 26, 1959

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) St. Louis, Missouri (State)

24. FUNERAL DIRECTOR ADDRESS
Bensiek-Niehaus Morticians. 1431 Union Blvd.

25. DATE REC'D BY LOCAL REG. AUG 24 '59

26. REGISTRAR'S SIGNATURE Earl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

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

working under my personal supervision.

Student_____ Signed Laurence O. Gerl

Signature of Student Embalmer

Licensed Embalmer No. 4979

P. O. Address St. Louis,

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