

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-034702

FILED VS SEP 21 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2275

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>DAYS</b>	c. CITY OR TOWN <b>Valda Village Hills</b> Inside Limits <b>3024-Capehart</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3024 Capehart</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Sciaratta</b> Last	4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1959</b>
---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1913</b>	9. AGE (last birthday) <b>46</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>6</b> Hours <b>0</b> Min.	IF UNDER 24 HR Hours <b>0</b> Min.
----------------------	-------------------------------	---	---	----------------------------------	--	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>ownhouse</b>	11. BIRTHPLACE (City and state or country) <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY <b>Italy</b>
---	--	--	---

13a. FATHER'S NAME <b>Joseph La Martina</b>	13b. MOTHER'S MAIDEN NAME <b>Rose Pirano</b>	14. NAME OF HUSBAND OR WIFE <b>Anthony</b>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Rosemary Glorioso</b> Address <b>3024 Capehart</b>
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Breast to Brain</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CA of Breast, blot</b>	
	DUE TO (c) <b>170x</b>	

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 <b>2:40</b> a.m. <b>PM</b> Month, Day, Year <b>Nov. 1957</b>
--

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 <b>Washington Blvd</b> COUNTY <b>St. Louis</b> STATE <b>MO</b>
--	--	--

21. I attended the deceased from **Nov. 1957** to **Aug 19, 1959** and last saw her <sup>her</sup> alive on **Aug 19, 1959**  
Death occurred at **2:40 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Adney Goldenberg MD</b> (Degree or title)	22b. ADDRESS <b>3720</b>	22c. DATE SIGNED <b>8/21/59</b>
--	-----------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL, SPECIFY	23b. DATE <b>Aug. 22-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis</b> (State) <b>MO</b>
--	--------------------------------	---	---

24. FUNERAL DIRECTOR <b>Miceli &amp; Sons</b> ADDRESS <b>1150 N. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>8-21-59</b>	26. REGISTRAR'S SIGNATURE <b>John G. Murphy M.D.</b>
--	--	---

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 Almo R. Jandrew

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.