URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042226

STATE FILE NUMBER

FILED VS NOV 20 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210302

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 7408 Minnesota Ave.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 7408 Minnesota Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MINNIE Middle Last MASCHERI

4. DATE OF DEATH: Month Nov. Day 7 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-4-1886
9. AGE (last birthday): 73
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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Jacob Ehrhardt
13b. MOTHER'S MAIDEN NAME: Carolyn Foltz
14. NAME OF HUSBAND OR WIFE: Late Charles Mascheri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Frances Krafft Address: 7408 Minnesota Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF THE RECTUM — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): 154X

O.K. [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): CONGESTIVE HEART Failure

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 3/20/59, to Nov 7, 1959 and last saw him alive on 6/4/59
Death occurred at 8:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Charles B. Lad M.D. (Degree or title)
22b. ADDRESS: 7430 Virginia Ave
22c. DATE SIGNED: 11/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov. 10, 1959
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG.: NOV 9 1959
26. REGISTRAR'S SIGNATURE: Karl 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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed William B White
Signature of Student Embalmer

Licensed Embalmer No. 4291

P. O. Address 228 So King

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