

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 4 7 8

FILED VS. JAN - 8 1960

211950

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5443 Magnolia</b>

3. NAME OF DECEASED (Type or print) First <b>ANTHONY</b> Middle <b>GRAVAGNA</b> Last	4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>59</b>
---	--

5. SEX <b>Male</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>9/8/1891</b>	9. AGE (last birthday) <b>68</b>	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) <b>Moulder</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY <b>Italy</b>
---	-----------------------------------	--	---

13a. FATHER'S NAME <b>Angelo Gravagna</b>	13b. MOTHER'S MAIDEN NAME <b>Josephine Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Mary</b>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>496-12-8100</b>	17. INFORMANT <b>Mary Gravagna, 5443 Magnolia</b>	Address
---	---	--	---------

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>CARCINOMA OF THE STOMACH - CARCINOMATOSIS 2 1/2 Y.</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <b>1517</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumonitis &amp; Pulmonary Congestion &amp; Atelectasis</b>	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 type="checkbox"/> NO <input checked="" 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>11:00</b> a.m. Month, Day, Year <b>12-23-59</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	COUNTY	STATE

21. I attended the deceased from **Oct 157** to **12-23-59** and last saw her him alive on **12-23-59**  
Death occurred at **11:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John W. M. Mahon, M.D.</b>	22b. ADDRESS <b>1325 So Grand</b>	22c. DATE SIGNED <b>12/24/59</b>
---	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-26-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>
---	------------------------------	--	--

24. FUNERAL DIRECTOR <b>Calcaterra Funeral Home, 5142 Daggett Ave.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>DEC 24 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
---	---------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INFORMED

through

of the

information

is to be

to the

x

with

the

which

is

to be

with

information

is to be

information

is to be

information

is

**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

*Robert M. Mur*

Licensed Embalmer No. 3749

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.