

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS DEC 21 1959 317

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3285 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri.</u> b. COUNTY <u>St. Louis.</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights, Mo.</u>		Length of stay in 1b <u>WKS.</u>		c. CITY OR TOWN <u>Normandy</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4436 Crestland, Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Maniaci</u> Last <u>Maniaci</u>			4. DATE OF DEATH Month <u>December</u> Day <u>8,</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/1896</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired shoe repair man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Shop</u>		11. BIRTHPLACE (City and state or country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown Maniaci</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>189-20-8435</u>	17. INFORMANT <u>Mary Maniaci, 4436 Crestland, Dr. Normandy.</u> 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) <u>Coronary of Heart</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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 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 _____ a.m. _____ p.m. Month, Day, Year _____							
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 <u>Oct. 1959</u> to <u>Dec. 8, 1959</u> and last saw ^{her} him alive on _____ Death occurred at <u>8</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William A. Gandy, M.D.</u>				22b. ADDRESS <u>4161 Lunder</u>		22c. DATE SIGNED <u>12/8/59</u>	
23a. FULL NAME (Specify) <u>Emilia</u>		23b. DATE <u>12-11-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR <u>Bensiek-Niehaus, 1431 N. Union, Ave.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>12-9-59</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

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

Robert M. Murray

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.