

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

**FILED VS FEB 1 0 1960**

**-60-004193**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2 783**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		e. STATE <b>Missouri</b> b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1713 a Park</b>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>Anthony</b> Middle <b>Viviano</b> Last			<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>21</b> Year <b>1960</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/23/13</b>	<b>9. AGE</b> (last birthday) <b>46</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>City of St. Louis</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis Mo</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>Louis Viviano</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Catherine Favazzo</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Dorothy Martin</b>	

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	<b>16. SOCIAL SECURITY NO.</b> <b>499-12-5894</b>	<b>17. INFORMANT</b> <b>Dorothy Martin 1713 a Park Ave</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pericarditis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <b>701.0</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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____

**21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.**  
Death occurred at **344 A** \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>Catrick J. Taylor</b>		<b>22b. ADDRESS</b> <b>1300 Clark</b>		<b>22c. DATE SIGNED</b> <b>1.22.60</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>Jan 25 60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>E.J. Schnur 3125 Lafayette</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>JAN 22 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Neal Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjb*

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas R. Jensen

Licensed Embalmer No. 3793

P. O. Address 3125 La

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.