

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

FILED VS FEB 1 1960

**=60-004552**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 158

1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Length of stay in 1b <b>1 day</b>		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>Normandy Osteopathic</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>8840 Murvale</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>John</b> Last <b>DeFiore</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>13,</b> Year <b>1960</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/2/1891</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>Dyer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Fouke Co.</b>		11. BIRTHPLACE (City and state or country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		
13a. FATHER'S NAME <b>Frank DeFiore</b>			13b. MOTHER'S MAIDEN NAME <b>Rose Genio</b>			14. NAME OF HUSBAND OR WIFE <b>Pauline DeFiore</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>497-01-2583</b>		17. INFORMANT Address <b>Medical Record Normandy Hospital</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>Cardiac arrest</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-2 min</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial Infarction</b>							<b>22 h</b>		
DUE TO (c) <b>Generalized Atherosclerosis</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>cerebral embolism</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 Month, Day, Year a.m. p.m.									
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 <b>1957</b> to <b>date above</b> and last saw her/him alive on <b>1-13-60</b> Death occurred at <b>4:55 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>George W. Wohlshlager D.O.</b>				22b. ADDRESS <b>6433 W Florissant 20</b>				22c. DATE SIGNED <b>1-14-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>1/18/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Buchholz Mortuary 5967 W. Florissant</b>				25. DATE RECD. BY LOCAL REG. <b>1-16-60</b>		26. REGISTRAR'S SIGNATURE <b>John M. ...</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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FEB 9

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 *J. Alfred J. B...*

Licensed Embalmer No. 4551

P. O. Address *St. Louis*

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