

**FEDERAL BUREAU OF INVESTIGATION  
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS APR 5 1960**

**60-013066**

**2 3322**

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>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5641 Columbia Ave.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ANGELO</b> Middle <b>A.</b> Last <b>PEROTTA</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>22</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 type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-1900</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer-Metropolitan</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sewer District</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>Ambrose Perotta</b>		13b. MOTHER'S MAIDEN NAME <b>Natalie Corolli</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Perotta</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>492-05-6517</b>		17. INFORMANT Address <b>Mary Perotta 5641 Columbia Ave.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>19 days</b>
IMMEDIATE CAUSE (a)	<b>Myocardial Infarction</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Coronary Perforation</b>	
DUE TO (b)		<b>19 days</b>
DUE TO (c)		<b>4201</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	
---	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 . 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>April 1957</b> to <b>March 22</b> and last saw him <del>live</del> <b>March 21</b> Death occurred at <b>12:05 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree of title) <b>William C. Turner, D.</b>	22b. ADDRESS <b>4401 Hampton</b>	22c. DATE SIGNED <b>3-22-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>March 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>

24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 23 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
--	--	--

DOCUMENT

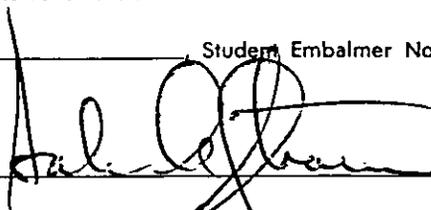
MEDICAL CERTIFICATION

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  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed  \_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.