

VISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016607

D VS. MAY 2 1960

2 4247

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5216 Columbia Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Maria Middle Berra Last Berra			4. DATE OF DEATH Month April Day 18 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1896	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Italy	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Pacifico Aina		13b. MOTHER'S MAIDEN NAME Maria Chester Cesti		14. NAME OF HUSBAND OR WIFE Louis Joseph Berra	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address John Berra, 5216 Columbia Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Mid-Brain DUE TO (b) arterio-sclerosis of Cerebral Vessels DUE TO (c) Hypertensive Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443x					INTERVAL BETWEEN ONSET AND DEATH 4 days
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 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 May 13 - 1957 , to April 18 - 1960 and last saw her ^{her} alive on April 17 - 1960 Death occurred at 220A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Charles Montani MD			22b. ADDRESS 5147 Daggett Ave		22c. DATE SIGNED 4-18-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-21-60	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR Calcaterra Funeral Home, 5142 Daggett Ave.			25. DATE RECD. BY LOCAL REG. APR 19 1960		26. REGISTRAR'S SIGNATURE Loan Smith M.D.

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

~~or by~~ _____, Student Embalmer

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Elton H. Pe

Licensed Embalmer No. _____

P. O. Address St. Y

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

• O • If this body is not embalmed, fact should be so stated above.