

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017807

FILED VS MAY 6 1960

317

Registration District No. 500

Primary Registration District No. 1390

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</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 lb <b>5 1/2 Months</b>		c. CITY OR TOWN <b>Cool Valley</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>Mother of Good Council Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1218 Haley</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Angelina</b> Middle <b>Longo</b> Last <b>Longo</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/25/90</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>12</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>Philadelphia, Penn.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>James Margarita</b>			13b. MOTHER'S MAIDEN NAME <b>Maria Norcia</b>		14. NAME OF HUSBAND OR WIFE <b>Jospeh</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>None</b>		17. INFORMANT Address <b>John J. Longo 1121 Haley</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>art. sclerotic cerebral pore disease, cerebral pore</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
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) <b>Diabetes mellitus</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 <b>2-3-58</b> to <b>4-27-60</b> and last saw her <sup>him</sup> alive on <b>4-26-60</b> Death occurred at <b>4:50</b> <sup>A</sup> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Wayne D. Golob, M.D.</b>				22b. ADDRESS <b>100 No Euclid</b>		22c. DATE SIGNED <b>4-28-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>4/29/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Stuart &amp; Sons 1225 Union Bl.</b>				25. DATE RECD. BY LOCAL REG. <b>4-29-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. [Signature]</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 Stanley H. Simpson

Licensed Embalmer No. 4419

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.