

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 1960

318

1003

-60-024341

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6373**

ENDED

| | | | | | | | |
|---|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 7mo. & 4 days | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6061 Hartford | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Prima Middle A. Last Boris | | | | 4. DATE OF DEATH Month 6 Day 21 Year 60 | | | |
| 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 1-1-1886 | 9. AGE (last birthday) 74 | 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) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY : at Home | | 11. BIRTHPLACE (City and state or country) Italy (N.C.) | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Caeser Pezzali | | | 13b. MOTHER'S MAIDEN NAME Delphina Unknown | | 14. NAME OF HUSBAND OR WIFE Late Felix Boris | | |
| 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. 488-10-3641a | | 17. INFORMANT Address Gloria Ferrario-6061 Hartford Str. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7mo. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | 416x | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Bronchopneumonia - 7mo. | | | | | | 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 checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input checked="" 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 11-16-59 to 6-21-60 and last saw her/him alive on 6-21-60 Death occurred at 12:05 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) John W. Beckham, M.D. | | | 22b. ADDRESS 5800 Arsenal | | | 22c. DATE SIGNED 6/21/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE June 23, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Calvary | | 23d. LOCATION (City, town, or county) St. Louis, Mo. | | 23e. STATE Mo. | |
| 24. FUNERAL DIRECTOR Kriegshauser-South, 4228 S.Kingshighway | | | 25. DATE RECD. BY LOCAL REG. JUN 22 1960 | | 26. REGISTRARS SIGNATURE Loan Smith, M.D. <i>ms</i> | | |

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 William B White

Licensed Embalmer No. 4291

P. O. Address 4228 Do King

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.