

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024631

FILED VS JUN 27 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6000 STATE FILE NUMBER

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		c. CITY OR TOWN St. Louis	
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 St. John's Hospital		d. STREET ADDRESS (If outside, give location) 2815 Hadley St.	
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 MIDDLE LAST VICTORIA J. JACKALONE			4. DATE OF DEATH Month Day Year June 11 1960
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1942
9. AGE (last birthday) 17		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-F. W. Woolworth Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Vito Jackalone	
13b. MOTHER'S MAIDEN NAME Genevieve Swafford		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Address Hatty Swafford 2815 Hadley St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Bilateral Atelectasis due to a large mucous plug in the main bronchus on the left.*
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) *thyroglossal cyst*
DUE TO (c) *markedly enlarged thymus.*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in (a), (b), or (c).
Cardiac Perit 239X
PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>While undergoing operation (removal of neck) at St. John's</i>
20c. TIME OF INJURY Hour s.m. p.m. 6 11 60	Month, Day, Year Hospital June 11th 1960	
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.) <i>Hosp.</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St. Louis Mo</i>

21. I attended the deceased from *8:25 A.M.* to *9:00 A.M.* and last saw her/him alive on *June 11th 1960*.
Death occurred at *St. John's Hospital* on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <i>Joseph J. Quinn</i>	(Degree of <i>MD</i>)	21b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>6-13-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>June 14, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake Charles Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>
24. FUNERAL DIRECTOR <i>Kriegshauser</i>	ADDRESS <i>9450 Olive St. Road</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 13 1960</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</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 R. W. Stoveland

Licensed Embalmer No. 4007

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.