URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JUL 12 1960

-60-024697

STATE FILE NUMBER

ENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6462

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	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital — Inside Limits Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location) 3839 Minnesota — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
DOMINIC		LATO	June	23	1960

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Male	White		10-17-1887	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Laborer(Retired)Water Dep't.-City of St. Louis		Italy	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Angelo Lato	Anna Canniartia	Mary N. Lato

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None		Angelo J. Lato	3839 Minnesota Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis, generalized — INTERVAL BETWEEN ONSET AND DEATH 8 Mo.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) carcinoma of rectum — 1 yr.

DUE TO (c) 154X

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Feb 1960, to June 23 and last saw her/him alive on June 23 60

Death occurred at 10:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John S. Sciortino (Name or title) — 22b. ADDRESS 3720 Washington — 22c. DATE SIGNED 6/24/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 23b. DATE June 27, 1960 — 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery — 23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Kriegshauser — ADDRESS 4228 S. Kingshighway Blvd. — 25. DATE RECD. BY LOCAL REG. JUN 24 1960 — 26. REGISTRAR'S SIGNATURE Noel Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed R.W. Storrsand

Signature of Student Embalmer

Licensed Embalmer No. 4007

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.