URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-024720

FILED VS JUL 1 1960

NDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6002 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Anthony's Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5305 Delor St.
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First SALVATORE Middle Last LO PORTO

4. DATE OF DEATH: Month June Day 11th Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Feb. 8, 1903
9. AGE (last birthday): 57
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): Owner
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store
11. BIRTHPLACE (City and state or country): Italy
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Francis LoPorto
13b. MOTHER'S MAIDEN NAME: Josephine D'Angelo
14. NAME OF HUSBAND OR WIFE: Concetta Lo Porto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 490-38-6390
17. INFORMANT: Address: Frank Lo Porto 5305 Delor St.

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) PULMONARY INFARCTIONS MULTIPLE — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — UNK
DUE TO (c) 420-D

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
① Polycythemia vera, ② Renal Insufficiency ③ Old Myocard Infarct.

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 Jan 1960, to June 11 1960 and last saw him alive on June 10 1960
Death occurred at 2:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Henry Cooper (Degree or title) MD.
22b. ADDRESS: 118 Olive St.
22c. DATE SIGNED: 6/12/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-14-60
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR: KRIEGSHAUSER
ADDRESS: 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG.: JUN 13 1960
26. REGISTRAR'S SIGNATURE: Earl Smith M.D. MJB

(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_____

Signature of Student Embalmer

Licensed Embalmer No. 3024

P. O. Address_____

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.