

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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FILED VS JUL 19 1960 318

1003

6469 -60-028327
 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Glasgow Village	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If outside, give location) 312 Lanark Road	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Eleanor M Gagliano	4. DATE OF DEATH Month Day Year June 23 1960
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5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1922	9. AGE (last birthday) 38	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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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) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Edward J. Dunn	13b. MOTHER'S MAIDEN NAME Gertrude M. Sagehorn	14. NAME OF HUSBAND OR WIFE Angelo Gagliano
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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. 490-12-9621	17. INFORMANT Mr. Angelo Gagliano, 312 Lanark Road
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial, mediastinal & perivascular DUE TO (b) Hemorrhage & Irreversible Shock DUE TO (c) & Rt Heart Failure due to fibrinogenopenia postpartum O.K. 2/23/60 Post Partum 9 days 6/22/60	INTERVAL BETWEEN ONSET AND DEATH None
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post Partum 9 days 6/22/60	PART III. If deceased was female, was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY a.m. p.m.	Month, Day, Year
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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 St. Louis	COUNTY Missouri	STATE
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21. I attended the deceased from 6/23/60 3 PM to 6/23/60 10:30 PM and last saw her alive on 6/23/60 Death occurred at 9:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Arthur R. Dalton M.D.	22b. ADDRESS 453 N. Taylor	22c. DATE SIGNED 6/25/60
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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 Missouri
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24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair	25. DATE RECD. BY LOCAL REG. JUN 25 1960	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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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

Glen W. Holt

Licensed Embalmer No. *W 5957*

P. O. Address *A. Lane*

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.