IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 9 1960 318 1003 6407 60-028608

STATE FILE NUMBER

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

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: DePaul Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Florissant
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2325 Palomino Lane
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: PAOLINA Middle: Last: MASTRANGELO
4. DATE OF DEATH: Month: June Day: 22 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 3-29-1896
9. AGE (last birthday): 64
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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Italy
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Salvatore Giordano
13b. MOTHER'S MAIDEN NAME: Rachael Unknown
14. NAME OF HUSBAND OR WIFE: Late Domenic Mastrangelo
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.: None
17. INFORMANT: Rachael Galletta Address: 2325 Palomino Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Cholangitis	5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hepatic Abscess	unknown
DUE TO (c)	Chronic Cholecystitis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 585x

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 6-10-60, to 6-22-60 and last saw her/him alive on 6-22-60
Death occurred at 11:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H. O. Schrepel, M.D. (Degree or title)
22b. ADDRESS: 634 No. Grand; St. Louis, Mo
22c. DATE SIGNED: 6-23-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal (Rail)
23b. DATE: June 24, 1960
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Fernwood, Pennsylvania
24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: JUN 23 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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. Lo

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.