

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033274

FILED VS, AUG 16 1960

ENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2237 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in 1b 2 hrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3276 Sulphur Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Infant Middle Last Pellicciotto	4. DATE OF DEATH Month July Day 23 Year 1960
--	--

5. SEX Male	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 7-22-1960	9. AGE (last birthday)	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) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	--	---

13a. FATHER'S NAME Angelo Pellicciotto	13b. MOTHER'S MAIDEN NAME Rosemary Copp	14. NAME OF HUSBAND OR WIFE Nil.
---	--	---

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. Nil.	17. INFORMANT Address Angelo Pellicciotto, 3276 Sulphur, Ave.
---	-------------------------------------	--

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) Immature Birth		2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Delivery at 20 weeks gestation	
	DUE TO (c)	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
--	---	--

20c. TIME OF INJURY Hour Hour Month, Day, Year	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	COUNTY	STATE
---	--	--	------------------------------	--------	-------

21. I attended the deceased from 7-22-60 to 7-23-60 and last saw her him alive on 7-23-60
Death occurred at 7-23-60 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Rosemary M.D.	22b. ADDRESS 607 N Grand	22c. DATE SIGNED 7-25-60
---	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, or REMOVAL (Specify) REMOVAL	23b. DATE 7-26-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
---	--------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc, 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. 7-26-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
---	---	--

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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