URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1960

-60-039512

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10405

ENDED

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Length of stay in 1b: 45yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES 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: JENNINGS s 20 — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5250 Jennings Rd — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First ROSE Middle MARIE Last BASILE
4. DATE OF DEATH: Month OCTOBER Day 26 Year 1960
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2?/ 21/85
9. AGE (last birthday): 65 — 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): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own house
11. BIRTHPLACE (City and state or country): Alabama
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Christopher DeLeonardo
13b. MOTHER'S MAIDEN NAME: Josephine
14. NAME OF HUSBAND OR WIFE: Nick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Address: Albert Basile 5250 Jennings Rd

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): Metastatic Carcinoma of the Brain — INTERVAL BETWEEN ONSET AND DEATH: 10 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Adenocarcinoma of the colon(Sigmoid) — 10 months
DUE TO (c): 153.3
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 5/20/60, to 10/26/60 and last saw her alive on 10/26/60
Death occurred at 2:43 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): F.R. Bradley MD F.R.Bradley, M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 10/26/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct 29/60
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): St. Louis, Mo
24. FUNERAL DIRECTOR: Miceli — ADDRESS: 1150 N. Kingshiway
25. DATE RECD. BY LOCAL REG.: OCT 27 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

BY AFFIDAVIT OF DOCUMENT

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 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..