

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040301

REGISTRATION DISTRICT NO. **318** OCT 26 1960

PRIMARY REGISTRATION DISTRICT NO. **1003**

REGISTRAR'S NO. **10220**

STATE FILE NUMBER

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  |   |   | Length of stay in 1b<br><b>3 wks.</b>  |  | c. CITY OR TOWN <b>Overland</b>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis Children Hospital</b>   |  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         |  | d. STREET ADDRESS (If outside, give location)<br><b>9071 Windom</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>John Hubert Terracina</b>  |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>10 20 1960</b>                                      |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/16/1960</b>   |  | 9. AGE (last birthday)<br><b>0</b>   | IF UNDER 1 YEAR<br>Mnths Days Hours Min.<br><b>3 4</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis County, Mo.</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>              |
| 13a. FATHER'S NAME<br><b>Samuel J. Terracina</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Marie Beirne</b>  |  |  | 14. NAME OF HUSBAND OR WIFE  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT Address<br><b>Marie Terracina 9071 Windom</b>                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Enteritis</b>  |  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10d</b>         |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Proteus morganii</b>  |  |   |   |  |  |  |  |
| DUE TO (c) <b>Pneumotococcus cystoides intestinalis</b>   |  |   |   |  |  |  | <b>4d.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>571.0</b>   |  |   |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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.) |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>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 <b>Oct. 11-1960</b> to <b>Oct. 20-1960</b> and last saw him alive on <b>Oct. 20-1960</b><br>Death occurred at <b>12:05</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Lawrence L. Smith M.D.</b>   |  |   |   | 22b. ADDRESS<br><b>St. Louis Children's Hospital</b>   |  |  | 22c. DATE SIGNED<br><b>10/21/60</b>                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/22/1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary</b>  |  | 23d. LOCATION (City, town, or county)<br><b>St. Louis Mo.</b>              |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Ortmann F Home 9222 Lackland Overland Mo.</b>  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 21 1960</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Harold Smith, M.D.</b>   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Al C Ortman

Licensed Embalmer No. 347

P. O. Address \_\_\_\_\_

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