

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO		Length of stay in 1b 60 YRS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 920 TYLER		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 920 TYLER	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE LAST JOHN LAMACCHIA			4. DATE OF DEATH Month Day Year Nov. 17 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12 1878	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE MAKER		10b. KIND OF BUSINESS OR INDUSTRY JOHANSON BROS.		11. BIRTHPLACE (City and state or country) ITALY	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME LAMACCHIA		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE AGUILENA LAMACCHIA		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. None	
17. INFORMANT AMELIA LAMACCHIA		Address 920 TYLER			

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 3
IMMEDIATE CAUSE (a) <u>Cardio-vascular Heart Disease</u>		
DUE TO (b) <u>Cerebral Hemorrhage</u>		
DUE TO (c) <u>422.1</u>		June 1-196
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.)
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20c. TIME OF INJURY Hour a.m. p.m. 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
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21. I attended the deceased from <u>July 1-1957</u> to <u>Nov 17-1960</u> and last saw him alive on <u>Nov 15-1960</u> Death occurred at <u>7:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>H. G. Moore M.D.</u> (Degree or title)	22b. ADDRESS <u>917-50186</u>	22c. DATE SIGNED <u>11/18/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov. 21 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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24. FUNERAL DIRECTOR <u>Thomas Lutes 2906 Gravois</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>NOV 18 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.  
Student \_\_\_\_\_ Signed James E. Hill  
Signature of Student Embalmer

Licensed Embalmer No. 4347  
P. O. Address 2906

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