RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 13 1961

-60-047914

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12590 STATE FILE NUMBER

NDED

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 HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Mother of Perpetual Help Nursing Home
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St Louis
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 2730 Ann Ave
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Mary Middle: Celia Last: Sedlak
4. DATE OF DEATH: Month: Dec Day: 29 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 11/10/80
9. AGE (last birthday): 80
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: Housework
11. BIRTHPLACE (City and state or country): St Louis Missouri
12. CITIZEN OF WHAT COUNTRY: U S
13a. FATHER'S NAME: John Trampier
13b. MOTHER'S MAIDEN NAME: Josephine Pinc
14. NAME OF HUSBAND OR WIFE: William (Deceased)
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.: 499-34-5759
17. INFORMANT: Anna Mack Address: 2730 Ann Ave

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): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — ?
DUE TO (c): 332x
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 2.4.60, to 12.29.60 and last saw her/him alive on 12.28.60
Death occurred at 2:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Carl Caciolo (Degree or title) M.D. M.D.
22b. ADDRESS: 4145 a S. Grand Blvd.
22c. DATE SIGNED: 12.30.60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/31/60
23c. NAME OF CEMETERY OR CREMATORY: S S Peter & Paul
23d. LOCATION (City, town, or county) (State): St Louis Missouri

24. FUNERAL DIRECTOR ADDRESS: Moydell Funeral Home 1926 Allen
25. DATE RECD. BY LOCAL REG.: DEC 30 1960
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

DOCUMENT

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 Shelley R. Fuller Jr

Licensed Embalmer No. 4950

P. O. Address St Louis

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