

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS, JAN 9 1961 317 500 3765-60-048355  
 Registration District No. Primary Registration District No. Registrar's No. STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch</b>		Length of stay in 1b <b>200 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rob't. Koch Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4429 Anderson</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Silvio Occhi</b>		4. DATE OF DEATH Month <b>12</b> Day <b>27</b> Year <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Unk.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNK</b>	11. BIRTHPLACE (City and state or country) <b>Italy</b>
13a. FATHER'S NAME <b>? ANTHONY OCCHI</b>		13b. MOTHER'S MAIDEN NAME <b>?</b>	14. NAME OF HUSBAND OR WIFE <b>Maria Occhi</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-03-8346?</b>	17. INFORMANT <b>Rob't. Koch Hospital, Koch, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebro-vascular Accident due to Thrombosis</b>		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	
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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 <b>p.m.</b> 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 <b>CO. MO.</b>	STATE <b>MO.</b>
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21. I attended the deceased from <b>6-10-60</b> to <b>12-27-60</b> and last saw her alive on <b>12-27-60</b> Death occurred at <b>6:50</b> <b>P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Bernard Friedman, M.D.</b>	22b. ADDRESS <b>Robt. Koch Hospital, Koch, Mo.</b>	22c. DATE SIGNED <b>12-27-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-30-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>SESSER MO.</b>
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24. FUNERAL DIRECTOR <b>Jay B. Smith</b>	ADDRESS <b>7456 Manchester</b>	25. DATE RECD. BY LOCAL REG. <b>12-28-60</b>	26. REGISTRAR'S SIGNATURE <b>James M. Murphy, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

*J.P. Burgess*

Licensed Embalmer No. ~~4477~~

P. O. Address

*Maplewood*

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