

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-012163

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 867

1. PLACE OF DEATH
 a. COUNTY St. Louis
 b. CITY (If outside corporate limits, give TOWNSHIP only) Valley Park Length of stay in 1b 2 weeks
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY St. Louis
 c. CITY OR TOWN St. Louis Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 5229 Pattison Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Rachele Middle Valloni Last Valloni
4. DATE OF DEATH Month March Day 28 Year 1961
5. SEX Female **6. COLOR OR RACE** White **7. Married** **Never Married**
8. DATE OF BIRTH 8/21/1879 **9. AGE (last birthday)** 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife **10b. KIND OF BUSINESS OR INDUSTRY** At Home **11. BIRTHPLACE** (City and state or country) Italy **12. CITIZEN OF WHAT COUNTRY** U.S.
13a. FATHER'S NAME Unknown **13b. MOTHER'S MAIDEN NAME** Unknown **14. NAME OF HUSBAND OR WIFE** Louis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No **17. INFORMANT** Angelo Valloni, 5229 Pattison

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 4 years
 DUE TO (b) 420.0
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____

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 **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 March 15, 1961, to March 28, 1961 and last saw her alive on 3-23-61
 Death occurred at 1:50 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert D. Sanders, M.D. **22b. ADDRESS** 1502 Cass St **22c. DATE SIGNED** 3-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE** 3-30-61 **23c. NAME OF CEMETERY OR CREMATORY** Resurrection Cemetery **23d. LOCATION** (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR Calcaterra **ADDRESS** 5140 DARGETT ST. **25. DATE RECD. BY LOCAL REG.** 3-29-61 **26. REGISTRAR'S SIGNATURE** John C. Murphy, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo

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.