

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY											
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>12 hours</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Christian Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>4112a Fairgrounds Pl</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L</u> Last <u>LA GREEK (LoChirco)</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1961</u>											
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11/29/1892</u>		9. AGE (last birthday) <u>68 years</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>Rosario Monterusso</u>				13b. MOTHER'S MAIDEN NAME <u>Caterina Lucido</u>				14. NAME OF HUSBAND OR WIFE <u>Paul LaGreek</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Joseph LaGreek - 3033 Meadowlark</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)					
										DUE TO (c) <u>4201</u>					
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 checked="" 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.)											
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.															
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 <u>Dec. 6 1960</u> to <u>April 25 61</u> and last saw her <u>live</u> on <u>April 25-61</u> . Death occurred at <u>9:45 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>M. Jost M.D.</u> (Degree or title)						22b. ADDRESS <u>3700 N Grand Ave</u>				22c. DATE SIGNED <u>4/27/</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>entombment</u>		23b. DATE <u>April 29, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Mausoleum</u>				23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>							
24. FUNERAL DIRECTOR <u>BUGHOLZ MORTUARY - 5967 West Florissant</u>					25. DATE RECD. BY LOCAL REG. <u>APR 28 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>								

**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 \_\_\_\_\_

Licensed Embalmer No. 4557

P. O. Address St James

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.