MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7337 STATE FILE NUMBER 61-027369

FILED AUG 14 1961

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hospital
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: Ferguson
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): ~~XXX~~ 707 Tiffin Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First JASPER Middle Last STALLONE
4. DATE OF DEATH: Month August Day 5 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/9/1889
9. AGE (last birthday): 72
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): Tailor
10b. KIND OF BUSINESS OR INDUSTRY: Amer. Formal Rental
11. BIRTHPLACE (City and state or country): Sicily
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Phillip Stallone
13b. MOTHER'S MAIDEN NAME: Ann
14. NAME OF HUSBAND OR WIFE: Vita Stallone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
17. INFORMANT: Mrs. Vita Stallone Address: 707 Tiffin 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 Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Vascular Disease — 3 yrs
DUE TO (c): 331.X
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 10-26-50, to 8-5-61 and last saw ~~her~~ him alive on 8-4-61
Death occurred at 12:01 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature], MD
22b. ADDRESS: 100 No Euclid . St. Louis Mo
22c. DATE SIGNED: 8-5-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Cremation 8/8/61
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Crematory
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri
24. FUNERAL DIRECTOR: JOHN STYGAR & SON ADDRESS: 5541 Riverview Blvd.
25. DATE REC'D. BY LOCAL REG.: AUG 7 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3980

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.