

MISSOURI DIVISION OF HEALTH - BUREAU OF VITAL RECORDS

-61-034889

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9118

STATE FILE NUMBER

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Length of stay in 1b <u>4 Days</u>	c. CITY OR TOWN <u>HILLSDALE</u> <del>St. Louis</del>		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>Cardinal Glennon Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2118 Rosebud</u>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Joseph</u> Last <u>Scalise</u>			4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>61</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/61</u>	9. AGE (last birthday) Months <u>4</u> Days <u>4</u> Hours <u>   </u> Min. <u>   </u>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Joseph Scalise</u>		13b. MOTHER'S MAIDEN NAME <u>Joan Webb</u>		14. NAME OF HUSBAND OR WIFE <u>None</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. <u>      </u>	17. INFORMANT <u>Joseph Scalise 2118 Rosebud</u>		
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>MECONIUM PERITONITIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>INTRAUTERINE</u>
DUE TO (b) <u>INTRAUTERINE MID BUD VULVULUS WITH PERFORATION</u>					<u>INTRAUTERINE</u>
DUE TO (c) <u>SMALL INTESTINAL ATRESIA</u>					<u>INTRAUTERINE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>756.2</u>					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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>756.2</u>			
20c. TIME OF INJURY Hour <u>   </u> Month, Day, Year <u>   </u>					
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>9/30/61</u> to <u>10/1/61</u> and last saw her/him alive on <u>10/1/61</u> Death occurred at <u>11:50 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John W. McManis M.D.</u>			22b. ADDRESS <u>1325 So. Grand</u>		22c. DATE SIGNED <u>10/2/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 3, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		
24. FUNERAL DIRECTOR <u>Miceli &amp; Sons 1150 N. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>OCT 3 1961</u>	26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>	

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
ITEM NO. SHOULD READ

BY AFFIDAVIT OF  
*And has put it in front of book*

DOCUMENT

MEDICAL CERTIFICATION

**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 Phil E. Embolwood

Licensed Embalmer No. Phil E. Embolwood

P. O. Address \_\_\_\_\_

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.