

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035183  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2557

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. <b>DATE OF DEATH</b> <u>SEP 29 1961</u> a. COUNTY <b>ST. LOUIS</b>		2. <b>USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>212 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADMIN. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5464 BISCHOFF AVE.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. <b>NAME OF DECEASED</b> (Type or print) First <b>JOE</b> Middle <b>BERRA</b> Last			4. <b>DATE OF DEATH</b> Month <b>9-9-61</b> Day Year			
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>3-19-92</b>	9. AGE (last birthday) <b>69 YEARS</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Milan, Italy</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>MARIA BERRA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	Mrs. Jean Nocchiero (Daughter) <b>5108 Daggett Ave., St. Louis, Mo.</b>			
18. <b>CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH <b>2-3 DAYS</b>	
IMMEDIATE CAUSE (a) <b>ENCEPHALOMALACIA, RECENT, LEFT PARIETO-OCCIPITAL LOBES</b>						
DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>						
DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS 332x</b>						
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 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.)				
20c. TIME OF INJURY Hour 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	COUNTY	STATE		
21. Was attended the deceased from <u>9-9-61</u> to <u>9-9-61</u> <del>XXXXXXXXXXXX</del> Death occurred at <u>10:50</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Robert W. Fendler</i>			22b. ADDRESS <b>M.D. VET. ADM. HOSP., JEFF. BRKS., MO.</b>		22c. DATE SIGNED <b>9-10-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9/13/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Bks Mo</b>			
24. FUNERAL DIRECTOR <b>Edward Fendler</b> ADDRESS <b>5611 South Grand Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>9-11-61</b>	26. REGISTRAR'S SIGNATURE <i>John M. Flynn M.D.</i>			

**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 Leo J. Budd

Licensed Embalmer No. 3989

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.