

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-039723**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2890

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**FILED OCT 24 1961**

1. PLACE OF DEATH  
 a. COUNTY ST. LOUIS  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RICHMOND HEIGHTS Length of stay in 1b 7 WKS  
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S Hosp. Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE ILL b. COUNTY ST. CLAIR  
 c. CITY OR TOWN O'FALLON Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) 401 E 4th ST. Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First LENNIE Middle VERCELLOTTI Last VERCELLOTTI 4. DATE OF DEATH Month OCT Day 13 Year 1961

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 10/24/87 9. AGE (last birthday) 73 IF UNDER 1 YEAR IF UNDER 24 HR  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEHOLD 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME 11. BIRTHPLACE (City and state or country) ITALY 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME JOHN CHIRI 13b. MOTHER'S MAIDEN NAME ROSE BARATONO 14. NAME OF HUSBAND OR WIFE CARO VERCELLOTTI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Caro VercelloTTi ILL Address O'FALLON

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Fracture  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) comp of myocardial and pericardial aneurysm cancer involving  
 DUE TO (c) bladder - causing pelvic abscess  
 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 6:45 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 6:45 P.M. to her and last saw him alive on Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John B. Murphy M.D. 22b. ADDRESS 508 No. Grand St. Louis 3 Mo 22c. DATE SIGNED 10-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 10/13/61 23c. NAME OF CEMETERY OR CREMATORY COLLEGE HILL 23d. LOCATION (City, town, or county) (State) LEBANON, ILLINOIS

24. FUNERAL DIRECTOR L.M. WOLFERSBERGER ADDRESS O'FALLON, ILL 25. DATE RECD. BY LOCAL REG. 10-13-61 26. REGISTRAR'S SIGNATURE John B. Murphy M.D.

**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 Frank Prokop

Licensed Embalmer No. 4956

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.