

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

11602 -61-046098
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11602

FILED DEC 18 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 6 Days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3629 Taylor Avenue, 15		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First PETER Middle BOVA Last				4. DATE OF DEATH Month December Day 11th , Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-21-1891		9. AGE (last birthday) 70		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) Retired Merchant				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Nicholas Bova				13b. MOTHER'S MAIDEN NAME Nunzia Bova				14. NAME OF HUSBAND OR WIFE -----					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Anthony Bova, 4607 Shenandoah Avenue,							
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>Cardiac insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>420.0</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 year</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 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 a.m. p.m. 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. I attended the deceased from <u>December 1960</u> to <u>December 12, 1961</u> and last saw ^{her} him alive on <u>December 12, 1961</u> Death occurred at <u>10:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>John T. Lewiston, M.D.</u>						22b. ADDRESS <u>634 N. Grand Blvd.</u>			22c. DATE SIGNED <u>Dec. 13, 1961</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-14-61		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis, Missouri					
24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri						25. DATE RECD. BY LOCAL REG. DEC 13 1961		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>					

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John A. Mlinar

Licensed Embalmer No. 4186

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.