

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-020253

STATE FILE NUMBER

Registration District No. **318** Primary Registrar District No. **1003** Registrar's No. **5353**

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 7 1962

VS 300
Rev. 4/59

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4 **0**
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF *Date of birth is correct.*

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in lb over 20 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		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 St. Louis State Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7422 South Levee St.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK			First Middle Last CARIBONNE			4. DATE OF DEATH May 24, 1962			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Unk Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1883		9. AGE (last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Formerly: Junk Dealer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY Italy			
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT St. Louis State Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute Myocarditis, viral											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Interstitial pneumonitis, viral, bilateral											
DUE TO (c) 525XH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchogenic carcinoma, left lower lobe								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 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 12-22-41 to 5-24-62 and last saw ^{her} him alive on 5-24-62 . Death occurred at 3:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE C. A. Valtierra, M.D.						22b. ADDRESS 5400 Arsenal St.			22c. DATE SIGNED 5-24-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/29/62		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis		23e. STATE Mo.			
24. FUNERAL DIRECTOR Cullen Kelly				ADDRESS 7267 Natural B ridge		25. DATE RECD. BY LOCAL REG. MAY 28 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

80

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. *Not Embalmed*

Student _____
Signature of Student Embalmer

Signed *James B. Lammers*

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.