

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004000

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003** Registrar's No. **728**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 31 1963

VS 300
Rev. 4/59

1
2 **2229**
3
4 **0**
5 **2**
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7 **0**
8 **1**
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11
12 **75-0**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

COZART
USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY																
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1304 S. 14TH			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Dan Middle Pupillo Last Pupillo			4. DATE OF DEATH Month Jan. Day 21 Year 63																
5. SEX MALE		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-7-1889		9. AGE (last birthday) 73		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) OWNER FRUIT & PRODUCE CO.				10b. KIND OF BUSINESS OR INDUSTRY MO				11. BIRTHPLACE (City and state or country) U.S.A.				12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME SALVATORE POPILLO				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE MARGARET POPILLO (DECD)											
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.				17. INFORMANT SALVATORE POPILLO				Address 5517 FAIR RIDGE CT. JENNINGS, MO.							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) EMPHYSEMA DUE TO (c) CHRONIC BRONCHITIS 502.0																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) OBesity								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 1-15-63 to 1-21-63 and last saw ^{her} him alive on 1-21-63 Death occurred at 3:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE D. J. Cozart, MD (Degree or title)						22b. ADDRESS 1515 Lafayette Avenue				22c. DATE SIGNED 1-21-63									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN 25, 1963		23c. NAME OF CEMETERY OR CREMATORY CALVARY Cem.				23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo.										
24. FUNERAL DIRECTOR Thomas Bates 2906 Gravois ADDRESS						25. DATE RECD. BY LOCAL REG. JAN 23 1963		26. REGISTRAR'S SIGNATURE Coart Smith, 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

J. A. Humphrey

Licensed Embalmer No.

4772

P. O. Address

2906 Yarrow's

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.