

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-017474

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4181**

FILED APR 23 1963

VS 300
Rev. 4/59

1

2 **204**

3

4 **1**

5 **2**

6

7 **2**

8 **2**

9

10

11

12 **86-0**

13

86

WRITE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|--|---|--|---|--|---|--|--|--|--|--|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri | | Length of stay in 1b 2 days | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | |
| 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. | | b. COUNTY | | c. CITY OR TOWN | | d. STREET ADDRESS 6109 Clayton | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Serafina (n.m.i.) Cavagnaro | | | 4. DATE OF DEATH Month Day Year April 14, 1963 | | | 5. SEX F | | 6. COLOR OR RACE W | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10-17-1875 | | 9. AGE (last birthday) 87 | | 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) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | | | 11. BIRTHPLACE (City and state or country) Pietalevasita, Italy | | | | 12. CITIZEN OF WHAT COUNTRY USA (Nat.) | | | | | | | |
| 13a. FATHER'S NAME Unknown Ghigliani | | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | | 14. NAME OF HUSBAND OR WIFE John Cavagnaro (Dec.) | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 17. INFORMANT Address Mrs. Mario Cavagnaro 8 Aberdeen Place | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Diabetes mellitus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 yr. 10+ yr. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x | | | | | | | | | | 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 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 April 1, 1963 to 14 April 1963 and last saw her alive on 12 April 1963 . Death occurred at 11:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | 22a. SIGNATURE Joseph B. Vance M.D. | | 22b. ADDRESS 3915 Watson Rd. | | 22c. DATE SIGNED 15 April 1963 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-17-63 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Missouri | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY SAM | | | | 25. DATE RECD. BY LOCAL REG. APR 15 1963 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | | | | | | | | | | | | | |

Dr. Joseph B. Vacca
3915 Watson
MI 74221

1130

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 Bia C. Branson

Licensed Embalmer No. 4964

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.