

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022478

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1652

FILED JUN 1 1963

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Ann</u>		Length of stay in 1b <u>10 years</u>	c. CITY OR TOWN <u>St. Ann</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3435 St. Marks Lane</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside; give location) <u>3435 St. Marks Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>LOUIS</u> Last <u>BALDUCCI</u>			4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>moving & storage</u>	9. AGE (last birthday) <u>36 years</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Alex Balducci</u>		13b. MOTHER'S MAIDEN NAME <u>Georgeann Hepburn</u>	14. NAME OF HUSBAND OR WIFE <u>Geraldine Balducci</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Geraldine Balducci - 3435 St. Marks Lane</u> Address _____	
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>Cocci meningitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cocci meningitis of lung, Anaglastic</u> DUE TO (c) _____ 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			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>6 months</u>
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>Feb 1963</u> to <u>Present</u> and last saw her/him alive on <u>May 19, 1963</u> Death occurred at <u>11 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George Hawkshaw, M.D.</u>		22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>May 22 63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>May 24, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>
24. FUNERAL DIRECTOR <u>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</u>		25. DATE RECD. BY LOCAL REG. <u>5-22-63</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

Rogers C. Linders

Licensed Embalmer No. 4 225

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.