

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17575  
Registrar's No. 4705

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>1 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Alexian Bros Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1518 N. 18th St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mercurio, also known as Mike Orlando.</u> b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>May. 27th 1949</u>				
5. SEX <u>Male</u> ✓	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 2. 1887</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vulcan Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY <u>Italy</u>	
13a. FATHER'S NAME <u>Joseph Orlando.</u>		13b. MOTHER'S MAIDEN NAME <u>Angie Sharamitaro</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Orlando.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>029-12-7272</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Maria Orlando 1518 N. 18th</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac Failure - Pneumonia</u>  ANTECEDENT CAUSES DUE TO (b) <u>Acute Pancreatitis</u> <u>Chronic Cholecystitis</u> DUE TO (c) <u>Pneumonia</u>  II. OTHER SIGNIFICANT CONDITIONS <u>Granulioarteriosclerosis</u>  Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  <u>4 wks.</u> <u>4 wks.</u>	
19a. DATE OF OPERATION <u>May 5</u>		19b. MAJOR FINDINGS OF OPERATION <u>Acute Pancreatitis Chronic Cholecystitis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis, St. Louis Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>1700 50 HX</u>			
22. I hereby certify that I attended the deceased from <u>April 15, 1949</u> , to <u>May 27, 1949</u> , that I last saw the deceased alive on <u>May 27, 1949</u> and that death occurred at <u>11:30 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. Casprial M.D.</u>				23b. ADDRESS <u>1901 Madison St</u>		23c. DATE SIGNED <u>5/29/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 31, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>MAY 30 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Soster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Beusch, Niehaus 1431 Union Blvd</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4205

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.

Signed.....

*Elmo J. Padwell*

Signed.....

Student Embalmer

Licensed Embalmer No. ....

4077

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.