

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAR 8 1950

No. 300

10-48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 524

1. PLACE OF DEATH: a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>CLAYTON</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Robertson</u>	
c. LENGTH OF STAY (in this place) <u>8 hrs.</u>		d. STREET ADDRESS (If rural, give location) <u>St. Charles &amp; Natural Bridge</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) _____ c. (Last) <u>MASSA</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 27 1950</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-3-93</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender &amp; Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Stefano Massa</u>		13b. MOTHER'S MAIDEN NAME <u>Angeline Pico</u>	
14. NAME OF HUSBAND OR WIFE <u>Maria DeVoto Massa</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>498-05-1208</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Maria Massa</u>		ADDRESS _____			

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>Hypertensive - Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Old myocardial infarction</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral hemorrhage</u>		DUE TO (c) _____		<u>12 hours</u>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____	
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>4:30 PM</u>	

22. I hereby certify that I attended the deceased from 2-27 1950, to 2-27 1950, that I last saw the deceased alive on 2-27 1950, and that death occurred at 5:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Albert Ishii</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>601 S. Brentwood, Clayton 5 mo.</u>		23c. DATE SIGNED <u>2-28-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-2-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
24d. LOCATION (City, town, or county) (State) _____					

DATE REC'D BY LOCAL REG. <u>MAR 1 1950</u>		REGISTRAR'S SIGNATURE <u>Albert S. Slonka, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Collins Funeral Home</u> ADDRESS <u>10143 St. Charles Rd.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 .....  
Student Embalmer

Signed *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address. *10123 St. Charles R.*

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.