

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25368

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6738			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis - Me. 24th</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>East St. Louis 8120</u>		d. STREET ADDRESS (If rural, give location) <u>1232 No. 43rd St.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 7-1950</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Michael</u> b. (Middle) <u>John</u> c. (Last) <u>Vallero</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>			
8. DATE OF BIRTH <u>July-26-1950</u>		9. AGE (In years last birthday) <u>12 days</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>East St. Louis - Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Joseph Vallero</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Marcus</u>			
14. NAME OF HUSBAND OR WIFE <u>Joseph Vallero</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Joseph V. Vallero</u> ADDRESS <u>1232 No. 43rd East St. Louis</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intercranial Hemorrhage</u> ANTECEDENT CAUSES <u>Birth Injury</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Prob. Broncho pneumonia</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>12 days</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>761.0</u>					
22. I hereby certify that I attended the deceased from <u>8-6-1950</u> , to <u>8-7-1950</u> , that I last saw the deceased alive on <u>8-7-1950</u> , and that death occurred at <u>5:15 p. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Wm. Kleinberg M.D.</u> (Degree or title) _____				23b. ADDRESS _____		23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>5</u>		24b. DATE <u>8</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Cornel</u>		24d. LOCATION (City, town, or county) (State) <u>Belleverille Ill.</u>			
DATE REC'D BY LOCAL REG. <u>AUG 8 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Sawyer</u>		FUNERAL DIRECTOR'S SIGNATURE <u>John J. Passy</u> ADDRESS <u>East St. Louis Ill.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 19 '57

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.....

Not Embalmed

working under my personal supervision.

Student Embalmer No.....

Signed *Eugene Chaplain*

Signed.....
Student Embalmer

Licensed Embalmer No. *Illinois 8320*

P. O. Address *Dupo, Illinois*

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.