

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2854**
Registrar's No. **0125**

BIRTHDAY **JAN 26 1952** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 20 89	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1004 Hornsby Ave.,		d. STREET ADDRESS (If rural, give location) 1004 Hornsby Ave.,	
3. NAME OF DECEASED (Type or Print) a. (First) PATRICK b. (Middle) PASQALE c. (Last) GUARIGLIA			4. DATE OF DEATH (Month) (Day) (Year) Jan 6th, 1952
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug 26th, 1864
9. AGE (In years last birthday) 87		if UNDER 1 YEAR Months Days	if UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber (retired)		10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (State or foreign country) Italy 5
12. CITIZEN OF WHAT COUNTRY? US		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Freida Guariglia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT'S SIGNATURE OR NAME Freida Guariglia, 1004 Hornsby Ave.,		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Cardio renal vascular disease Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio renal vascular disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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? W42X			
22. I hereby certify that I attended the deceased from Jan 4 , 19 52 , to Jan 6 , 19 52 , that I last saw the deceased alive on Jan 6 , 19 52 , and that death occurred at 7:50 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W P Hamilton M D		23b. ADDRESS 836 3 Halls Ferry	
23c. DATE SIGNED Jan 7 - 52			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 1/9/52	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, M.	
DATE RECEIVED BY LOCAL REG. Jan 7 1952		REGISTRAR'S SIGNATURE Earl Smith M D	
25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home		ADDRESS 8319 Hallsferry	

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

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 Eleanor Poirnee

Licensed Embalmer No. 3403

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