

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26288

FILED JUL 22 1952

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6568**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY OR TOWN St. Louis		a. STATE Washington, D. C.	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 119 Trenton XXXXXX	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) HILDA	b. (Middle)	c. (Last) SCARNCARELLI	(Month) July	(Day) 6	(Year) 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) Abt. 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Italy		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Pietro Ficia	13b. MOTHER'S MAIDEN NAME Elvira Vitale	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Rose Winakur-Washington, D.C.	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular accident		
	ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic heart disease		
DUE TO (c)		5 yrs.x	
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 checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from **Jan 1, 1952**, to **July 6, 1952**, that I last saw the deceased alive on **July 6, 1952** and that death occurred at **11:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Bette Harris Smor, M.D.	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 7/7/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/7/52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) Queens, New York, Y.
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DATE REC'D BY LOCAL REG. JUL 7 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Howard ...	ADDRESS 5216 ...
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(Licensed Embalmer's Statement on Reverse Side)

Date of Embalming (See Form)

Name of Deceased (See Form)

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..... *Edw. B. DeBrouilhat*

Licensed Embalmer No. *3691*

P. O. Address *Richmond Heights*

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.

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REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6568

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Washington, D.C. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis State Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington	
3. NAME OF DECEASED (Type or Print)		d. STREET ADDRESS (If rural, give location)	
a. (First) Ildegonda "Hilda" HELENA		b. (Middle) Figlia Scancarelli SCANCARELLI	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 6, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Unknown Divorced	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) Abt. 65		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Sicily Italy
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Pietro Figlia	
13b. MOTHER'S MAIDEN NAME Elvira Vitale		14. NAME OF HUSBAND OR WIFE Divorced-Vincent Scancarelli	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Rose Winakur-Washington, D.C.		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 Vascular accident		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease		5 yrs. x	
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 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)			
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 4200			
22. I hereby certify that I attended the deceased from Jan 1, 1952 , to July 6, 1952 , that I last saw the deceased alive on July 6, 1952 and that death occurred at 11:15 am , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Bette Harris Simon, M.D.		23b. ADDRESS 5100 Arsenal St.	
23c. DATE SIGNED 7/7/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7/7/52	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) Queens, New York, N.Y.	
DATE REC'D BY LOCAL REG. JUL 7 1952		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Harold ...		ADDRESS 5214 ...	
(Licensed Embalmer's Statement on Reverse Side)			

Items # 3, 7, 11, 13a, 14 amended by affidavit of Granddaughter of deceased 6-8-94