

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6233**
Registrar's No. **1825**

BIRTH NO. **FILED MAR 8 1954** 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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY OR TOWN St. Louis	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 5121 Wilson Ave.		e. STREET ADDRESS (If rural, give location) 13 5121 Wilson Ave. 2139	
3. NAME OF DECEASED (Type or Print) VIRGINIA		a. (First) GRECO	b. (Middle) GRECO
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Feb. 23 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sep. 25, 1886
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (City and State or Foreign Country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Michael Tummunia	13b. MOTHER'S MAIDEN NAME Agnes Unknown
14. NAME OF HUSBAND OR WIFE Vincent Greco		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 Vincent Greco		ADDRESS 5121 Wilson Ave.	
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) Cerebral Apoplexy INTERVAL BETWEEN ONSET AND DEATH 1 hour ANTECEDENT CAUSES DUE TO (b) Arterio Sclerotic Heart Dis 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? 4200	
22. I hereby certify that I attended the deceased from 2-23 , 19 54 to _____, 19____, that I last saw the deceased alive on 2-23 , 19 54 and that death occurred at 5:00P m., from the causes and on the date stated above.			
23a. SIGNATURE Duane J. Leopold MD		(Degree or title)	23b. ADDRESS 1931 Marconi
23c. DATE SIGNED 2-25-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 26, 1954	24c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. FEB 25 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	
		ADDRESS 4228 S. Kingshighway B1.	

WRITE PLAINLY—USING UNFADING 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.....
Signature of Student Embalmer

Signed *William B. White*.....

Licensed Embalmer No. *429*.....

P. O. Address *4228 S. King*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.