

FILED MAY 25 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 17243  
Registrar's No. 4334

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4334			
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, Mo.		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 5312 Northrup Ave.				e. STREET ADDRESS (If rural, give location) 13 5312 Northrup Ave. 2126					
3. NAME OF DECEASED (Type or Print) Celesta		a. (First)		b. (Middle) Ariaghi		c. (Last) Molla			
4. DATE OF DEATH		(Month) May		(Day) 14,		(Year) 1954.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Apr. 18, 1897			
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home.			11. BIRTHPLACE (City and State or Foreign Country) Italy			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME Carlo Barni		13b. MOTHER'S MAIDEN NAME Clara Unk.		14. NAME OF HUSBAND OR WIFE Mario Molla (DCSD)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give reg. or dates of service) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT'S SIGNATURE OR NAME Josephine Fasani, 5312 Northrup 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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of uterus with extensive abdominal metastases ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 7 years	
19a. DATE OF OPERATION 1952		19b. MAJOR FINDINGS OF OPERATION Intestinal obstruction due to pelvic carcinoma				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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 174X					
22. I hereby certify that I attended the deceased from April 15, 1954, to May 14, 1954, that I last saw the deceased alive on May 12, 1954, and that death occurred at 5 <sup>22</sup> A. m., from the causes and on the date stated above.									
23a. SIGNATURE Ernest B. Drescher (Degree or title) M.D.				23b. ADDRESS 3720 Washington Blvd		23c. DATE SIGNED 5-14-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-17-54		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		24d. LOCATION (City, town, or county) St. Louis, Mo. (State) _____			
DATE REC'D BY LOCAL REG. MAY 14 1954		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Paul C. Calcaterra, 5140 Daggett Ave.		ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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 *John S. Demme*.....

Licensed Embalmer No. *419*.....

P. O. Address *St. Louis*.....

**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.**