

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23446**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6117**

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). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital (Taylor)		STREET ADDRESS (If rural, give location) 5930 Lalite Ave	
3. NAME OF DECEASED a. (First) Mary b. (Middle) c. (Last) Beatrice		4. DATE OF DEATH (Month) (Day) (Year) July 14 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 15 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress presser		10b. KIND OF BUSINESS OR INDUSTRY Dress	9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frank Copple		13b. MOTHER'S MAIDEN NAME Theresa Marseal	14. NAME OF HUSBAND OR WIFE Pete Beatrice
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 492-03-1044	17. INFORMANT'S SIGNATURE OR NAME Pete Beatrice ADDRESS 5930 Lalite 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. Coronary Artery Occlusion ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with myocardial infarct 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from 9/14 , 1953, to 7/14 , 1955, that I last saw the deceased alive on 7/14 , 1955, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Joseph B. Succione M.D.		23b. ADDRESS 2801 N. Taylor	23c. DATE SIGNED 7/15/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/18/55	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REG. JUL 15 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's ADDRESS 2849 No. Euclid Ave.	

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

Alfred Mayfield

Licensed Embalmer No. *36*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.