

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 18 1955

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State File No. 38130  
Registrar's No. 9541

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 9541			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>ST. LOUIS, MISSOURI</u> )		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>2904 N. Union</u>					
3. NAME OF DECEASED (Type or Print) <u>JOSEPH</u>		a. (First)		b. (Middle)		c. (Last) <u>CURIA</u>			
4. DATE OF DEATH		(Month) <u>OCT. 29,</u>		(Day) <u>1955.</u>		(Year)			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>March 9, 1874</u>			
9. AGE (In years last birthday) <u>82</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Retired 20 Yrs.)</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Italy</u>			
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>		13a. FATHER'S NAME <u>Joseph Curia</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Late Catherine Curia</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Rosemary Combs</u> ADDRESS <u>3204 Hawthorne</u>					
18. CAUSE OF DEATH Enter only one cause per (a), (b), and (c) <i>This does not mean mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bacter - intestinal hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cirrhosis of liver</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pyelonephritis 58-1-0</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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. HOW DID INJURY OCCUR? _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>10-9-</u> , 1955, to <u>OCT. 29,</u> , 1955, that I last saw the deceased alive on <u>10-29-</u> , 1955, and that death occurred at <u>7:20p.</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Galen B. Cook M.D.</u>				23b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		23c. DATE SIGNED <u>10-31-55.</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 2, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>NOV 1 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway Bl.</u>					

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 *Richard W. H. [Signature]*

Licensed Embalmer No. *40*

P. O. Address.....

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.