

FILED JUN 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 12847
Registrar's No. 4929

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File No. 12847		Registrar's No. 4929			
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) Life		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 Reg. 1014 Fairmount					e. STREET ADDRESS (If rural, give location) 1014 Fairmount						
3. NAME OF DECEASED (Type or Print) Catherine			a. (First)		b. (Middle) NMI		c. (Last) Fontana		4. DATE OF DEATH (Month) (Day) (Year) May 21, 1956		
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH October 18, 1866		9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME John DeVoto				13b. MOTHER'S MAIDEN NAME Marie Caferata			14. NAME OF HUSBAND OR WIFE Louis Fontana				
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. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Beatrice Graffigna					ADDRESS 1014 Fairmount
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 Vas Accident						INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerosis						yes. je		
			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 331X						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?						
22. I hereby certify that I attended the deceased from 1953, 19, to May 21, 1956, that I last saw the deceased alive on May, 1956, and that death occurred at 9:200 m., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) William A. Keefe MD					23b. ADDRESS 4161 Leaside			23c. DATE SIGNED 5/21/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 23, 1956		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			24d. LOCATION (City, town, or county) (State) St. Louis, Mo				
DATE REC'D BY LOCAL REG. MAY 22 1956		REGISTRAR'S SIGNATURE J. Carl Smith MD			25. FUNERAL DIRECTOR'S SIGNATURE Alexander & Sons 6175 Delmar						

(Licensed Embalmer's Statement on Reverse Side)

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

Dr W^m Knight Jr
4100 Lumber
ol 2-2638
Tel 15

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 *Geo. E. McCulloch*.....
Licensed Embalmer No. *276*.....

P. O. Address *617 1/2*.....

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.