

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020029  
STATE FILE NUMBER

318

1003

5852

FILED JUN 11 1958

Registration District No.

Primary Registration District No.

Registrar No.

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY                                     |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits<br>OR TOWN <u>St. Louis MO</u> Yes <input type="checkbox"/> No <input type="checkbox"/>   |                               | c. CITY OR TOWN <u>St. Louis</u> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                      |  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1426 N. Market</u> Length of stay in 1b  |                               | d. STREET ADDRESS <u>1426 N. Market</u> (If outside give location) Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>              |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u></u> Last <u>Bellicotti</u>   |                               | 4. DATE OF DEATH<br>Month <u>5</u> Day <u>30</u> Year <u>58</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEAR MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>00</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrician</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Mo.</u>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                               | 13. FATHER'S NAME<br><u>None</u>   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>None</u>   |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or date of service)<br><u>None</u>                                     |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>  |                               | 17. INFORMANT<br><u>E. Taylor</u> Address <u>1300 Clark</u>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ |                               |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Coronary thrombosis</u> |
| 20c. TIME OF INJURY<br>Hour _____ a. m. _____ p. m. _____   |                               |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>                 |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  | 20f. CITY, TOWN, OR LOCATION<br><u>St. Louis</u> COUNTY _____ STATE _____  |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.   |                               |  |  |
| 22a. SIGNATURE<br><u>James M. Kelly</u> (Signature or title) <u>Deputy Coroner</u>  |                               | 22b. ADDRESS<br><u>1300 Clark</u>  | 22c. DATE SIGNED<br><u>6-2-58</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>removal</u>   | 23b. DATE<br><u>6-6-58</u>    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Lebanon Cemetery</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Co., Mo.</u>   |
| 24. FUNERAL DIRECTOR<br><u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington</u>   |                               | 25. DATE RECD. BY LOCAL REG.<br><u>JUN 5 '58</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith</u>   |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Specialty that must be causally related. Coroner cannot certify to a death due to natural causes. All diseases in Part I must be causally related.

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 .....  
Licensed Embalmer No. ....

*Not Embalmed*  
*Lawrence G. Meyer*

P. O. Address .....

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.