

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037674

STATE FILE NUMBER

10223

FILED NOV 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registration District No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis, Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSP. #1.		Length of stay in lb 257	d. STREET ADDRESS (If outside, give location) 912a Carr Street
3. NAME OF DECEASED (Type or print) First Middle Last Antonino Catarinicchia		4. DATE OF DEATH Month Day Year OCT. 24, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1869
9. AGE (In years last birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) American Foundry	11. BIRTHPLACE (City and state or country) Italy	12. CITIZEN OF WHAT COUNTRY? Italy
13a. FATHER'S NAME Vito Catarinicchia		13b. MOTHER'S MAIDEN NAME Angela (unknown)	14. NAME OF HUSBAND OR WIFE Josie
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. No	17. INFORMANT Address Josie 912a Carr St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheobronchitis - DUE TO (b) Adenocarcinoma of colon DUE TO (c) 153.8 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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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	COUNTY	STATE
21. I attended the deceased from 8/31/58 to 10/24/58 and last saw her/him alive on 10/24/58 Death occurred at 11:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dress or title) Cornelius J. O'Connor, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 10/24/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/27/58	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.
24. FUNERAL DIRECTOR Miceli & Son Funeral,		ADDRESS Kingshighway	DATE RECD. BY LOCAL REG. OCT 25 1958
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: Must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Anthony Mucchi*

Licensed Embalmer No. *4277*

P. O. Address *Alone*

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.