

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046294

STATE FILE NO. 12313

LED JAN 5 1959

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

300
-57

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, give TOWNSHIP only) OR TOWN <u>St Louis Mo</u>		c. CITY OR TOWN <u>St Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo Baptist Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>824 Cole Str.</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles (Sciortino) Scotino</u>			4. DATE OF DEATH Month Day Year <u>12-19-58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1896</u>		9. AGE (In years last birthday) <u>62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wagner Electric</u>		11. BIRTHPLACE (City and state or country) <u>Italy</u>	

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Scotino</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <u>Yes W.V.O.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Anna Scotino 824 Cole Str</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>3 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Pulmonary edema</u>			

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.) <u>420.0</u>		
20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.					

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 COUNTY STATE	
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21. I attended the deceased from Mar 1948 to Dec. 18, 1958 and last saw him alive on 12-18-58
Death occurred at 4:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Louise J. Verdant</u>		22b. ADDRESS <u>4500 Olive</u>		22c. DATE SIGNED <u>12-19-58</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-22-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	
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24. FUNERAL DIRECTOR ADDRESS <u>JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 20 58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D. S.P.</u>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. M. Ristie*

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

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.