

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010655

STATE FILE NUMBER

2-1823

LEO MAR 18 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
1-57
23
5
20
0

1. PLACE OF DEATH a. COUNTY <u>---</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Berkeley</u> <u>4000</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda General Hospital</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>8537 Redfir</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Kim</u> Middle <u>Victoria</u> Last <u>Alberici</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>1959</u>	
---	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-59</u>	9. AGE (In years last birthday) Months <u>2</u> Days <u>9</u> Hours <u>20</u>
-------------------------	----------------------------------	---	------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
---	---	--	--

13a. FATHER'S NAME <u>Theodore Robert Alberici</u>	13b. MOTHER'S MAIDEN NAME <u>Norma Jean Rau</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name & unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>Mrs. Norma Jean Alberici, 8537 Redfir,</u> Address <u>Berkeley, Mo.</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>atelectasis</u> DUE TO (b) <u>chronic obstructive pulmonary disease</u> DUE TO (c) <u>premature death 762.5</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
--	--	----------------------------	---------------------

21. I attended the deceased from 2:15 P.M. to 2-19-59 and last saw her/him alive on 2-19-59
Death occurred at 7 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. O. Riley</u> (Degree or title)	22b. ADDRESS <u>4660 Maryland</u>	22c. DATE SIGNED <u>2-20-59</u>
---	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/20/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS PETER & PAUL CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, Mo.</u>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <u>J L ZIEGENHEIN & SONS</u>	ADDRESS <u>7027 GRAVOIS</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 20 '59</u>	26. REGISTRAR'S SIGNATURE <u>Coan Smith M.D.</u>
--	--------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 no embalming, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed W. M. West

Licensed Embalmer No.
P. O. Address 7027 Grove

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.