

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011781

STATE FILE NUMBER

982

APR 6 1959

Registration District No.

317

Primary Registration District No.

531

Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WELLS TOWNSHIP UNIVERSITY CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>WELLS TOWNSHIP UNIVERSITY CITY</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6170 PLYMOUTH</b>		Length of stay in lb <b>YRS</b>	d. STREET ADDRESS (If outside, give location) <b>6170 PLYMOUTH</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSARIA RALLO</b>			4. DATE OF DEATH Month Day Year <b>MARCH 31, 1959</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 25, 1890</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and state or country) <b>UNKNOWN ITALY</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
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13a. FATHER'S NAME <b>UNKNOWN</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>THOMAS RALLO</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>189-03-7724A</b>	17. INFORMANT <b>JOSEPH RALLO</b> Address <b>8145 TODDY 21, WELSTON</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>57 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial Infarct</b>		
DUE TO (c) <b>Terminal Pneumonia</b>		
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? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	20d. 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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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
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21. I attended the deceased from **March 1958** to **March 1959** and last saw <sup>her</sup>him alive on **3/20/59**  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <b>Martha Glass, D.O.</b>	22b. ADDRESS <b>5507 Pershing Avenue</b>	22c. DATE SIGNED <b>2</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>APRIL 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>STROOT CARROLL</b> ADDRESS <b>4600 NATURAL BRIDGE AVE.</b>	25. DATE RECD. BY LOCAL REG. <b>4-1-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature for their id. No symptoms with asterisk. All diseases in Part I must be causally related.

DR GLAZER  
5507 PERRY ST  
1:00 PM TO 8:00 PM  
CALL FIRST → FO 7-4448

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 M. W. Ruetter .....

Licensed Embalmer No. 4865 .....  
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.