

FEDERAL BUREAU OF INVESTIGATION  
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030346

FILED VS SEP 1 1959

2 7691

STATE FILE NUMBER

INDEXED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ 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> COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis.</b>	Length of stay in 1b <b>2 Mo. 20 Days.</b>	c. CITY OR TOWN <b>St. Louis,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1310 A. Montgomery</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Giovanna</b> Last <b>Dimiceli.</b>			4. DATE OF DEATH Month <b>August</b> Day <b>16,</b> Year <b>1959</b>	
---	--	--	---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3 1885</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	---	-------------------------------------	--	--

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>own house</b>	11. BIRTHPLACE (City and state of country) <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY <b>Italy</b>
---	---	--	---

13a. FATHER'S NAME <b>Pete Limonni</b>	13b. MOTHER'S MAIDEN NAME <b>Mary</b>	14. NAME OF HUSBAND OR WIFE <b>Phillip</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>---</b>	16. SOCIAL SECURITY NO. <b>498-03-4639</b>	17. INFORMANT Address <b>Marie Fleming 1150 Astoria Dr</b>
--	---	---

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>Diabetes Mellitus</b> DUE TO (b) <b>59</b> DUE TO (c) _____ Conditions, if any, which may have arisen above cause (a), listing the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mo.</b>
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rt. I.T. Fract. - post op. 3/28/59</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <b>yes</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Fall from bed + hurt rt. hip.</b>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Louis County Hosp. treated + transferred to City Hosp. St. Louis</b>	

21. I attended the deceased from **May 26, 1959** to **August 16, 1959** and last saw her alive on **August 16, 1959**  
 Death occurred at **8:50 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>	22b. ADDRESS <b>5800 Arsenal</b>	22c. DATE SIGNED <b>8/17/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 20-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis</b>	24. FUNERAL DIRECTOR <b>Miceli &amp; Sons 1150 N. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 1 9'59</b>
26. REGISTRAR'S SIGNATURE <b>Harold Smith M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert M. Mur

Licensed Embalmer No. 3749

P. O. Address St Louis

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.