

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038404

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2677

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| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>St. Louis</u> | a. STATE <u>Mo.</u> | b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hts.</u> | Length of stay in 1b <u>2 Months</u> | c. CITY OR TOWN <u>St. Louis</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>St. Mary's Hosp.</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6132 Pershing Ave.</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-----------------------|--------|----------------------|-------------------------|-------------------|--------------|------------------|
| 3. NAME OF DECEASED (Type or print) | First <u>CARMELLA</u> | Middle | Last <u>ZARLENGA</u> | 4. DATE OF DEATH | Month <u>Oct.</u> | Day <u>6</u> | Year <u>1959</u> |
|--|-----------------------|--------|----------------------|-------------------------|-------------------|--------------|------------------|

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| 5. SEX <u>Female</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>6-13-1924</u> | 9. AGE (last birthday) <u>35</u> | IF UNDER 1 YEAR | IF UNDER 24 HR |
| | | | | Months | Days | Hours Min. |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Joseph Loduca</u> | 13b. MOTHER'S MAIDEN NAME <u>Rose Catalano</u> | 14. NAME OF HUSBAND OR WIFE <u>Sam Zarlenga</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u> | 17. INFORMANT <u>Sam Zarlenga</u> | Address <u>6132 Pershing Ave.</u> |
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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: | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cerebral Emboli</u> | <u>2 min</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <input checked="" type="checkbox"/> DUE TO (b) <u>Bacterial Endocarditis</u> | |
| <input checked="" type="checkbox"/> DUE TO (c) <u>Pseudomonas Septicemia</u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Pyelonephritis</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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. _____ p.m. | Month, Day, Year _____ |
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|---|---|-------------------------------------|---------------|--------------|
| 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 <u>10:55 A.</u> to <u>Oct 6, 1959</u> and last saw her <u>Oct 6, 1959</u> alive on | Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Ink or blue) <u>Mathew H. Austin MD</u> | 22b. ADDRESS <u>634 N. Grand Blvd</u> | 22c. DATE SIGNED <u>10-8-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Oct. 9, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Kriegshauser</u> | ADDRESS <u>4228 S. Kingshighway</u> | 25. DATE RECD. BY LOCAL REG. <u>10-8-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> |
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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 R. W. Stovessand

Licensed Embalmer No. 4007

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.