

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH** -60-008113

FILED VS MAR 8 1960

2 2333

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>3510a Barrett Street.,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Pietro</b> Middle _____ Last <b>DeLuca</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>26</b> Year <b>1960</b>			
<b>5. SEX</b> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>	<b>6. COLOR OR RACE</b> White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/27/1883</b>	<b>9. AGE</b> (last birthday) <b>76</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Grocer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Grocery</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Italy</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>Giochino DeLuca</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Julia LaBono</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Grazia DeLuca</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/> Nil <input type="checkbox"/>		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <b>Mrs. Grazia DeLuca, 3510a Barrett Street.,</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>terminal bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years</b>  <b>years</b>  <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertrophy of prostate 4200</b>				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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>4200</b>			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____	
<b>21. I attended the deceased from</b> <b>April 23, 1956</b> to <b>2/26/60</b> and last saw him alive on <b>2/26/60</b> Death occurred at _____ o'clock on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <b>Max J. Franklin M.D.</b>		<b>22b. ADDRESS</b> <b>607 N. Grand Ave.</b>		<b>22c. DATE SIGNED</b> <b>2/27/60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE</b> <b>3/1/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Missouri.</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Biesiek-Niehaus, 1431 Union Blvd.,</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>FEB 29 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Loan Smith, M.D.</b> <b>m.g.13.</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. Murray  
Licensed Embalmer No. 374

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.