

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013688

FILED VS MAR 3 0 1960

317 Primary Registration District No. 590 500 Registrar's No. 846

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. John's</u> Length of stay in 1b <u>4 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8675 Engler</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. John's</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>8675 Engler</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>Julius</u> Middle <u>R.</u> Last <u>Pello</u>			4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1960</u>				
5. SEX <u>Male</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>4/6/87</u>	9. AGE (last birthday) <u>72</u>	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) <u>retired Shoe worker</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (City and state or country) <u>Estonia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Paaro Pello</u>		13b. MOTHER'S MAIDEN NAME <u>do not know</u>		14. NAME OF HUSBAND OR WIFE <u>Olga Pello</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>477-34-3733</u>		17. INFORMANT Address <u>Harold Pello 8675 Engler</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>Metastatic Carcinomatosis of the Brain</u> DUE TO (b) <u>Prostatic Carcinoma</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</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>Generalized Arteriosclerosis</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.)		
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 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		

21. I attended the deceased from February 2, 1960 9:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. and last saw him alive on March 8, 1960

22a. SIGNATURE (Degree or title) <u>William A. Gearhart, M.D.</u>		22b. ADDRESS <u>8711 St. Charles Rock Road, St. Louis, Mo.</u>		22c. DATE SIGNED <u>3/9/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/12/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F. Home 9222 Lackland</u>		25. DATE RECD. BY LOCAL REG. <u>3-11-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Muffly, M.D.</u>		

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 Al C Ortman

Licensed Embalmer No. 3478

P. O. Address _____

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.