

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-016880

FILED VS. APR 22 1960

2 4033

STATE FILE NUMBER

Primary Registration District No. Registrar 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>MO.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		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>De Paul Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>821a North 8th Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Angelina Guiffrida</b>				4. DATE OF DEATH Month Day Year <b>April 11, 1960</b>				
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"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 28 1894</b>		
9. AGE (last birthday) <b>66</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>Chef</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>		11. BIRTHPLACE (City and state or country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY <b>Italy</b>	
13a. FATHER'S NAME <b>Vincent Comparato</b>			13b. MOTHER'S MAIDEN NAME <b>Antoinette Sanfillippo</b>			14. NAME OF HUSBAND OR WIFE <b>Sylvester</b>		
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>499-26-4957</b>		17. INFORMANT Address <b>Peter Guiffrida 821a North 8th St.</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>Intracerebral carcinoma to brain</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Generalized carcinomatous</b> DUE TO (c) <b>Adenocarcinoma, left breast 170X</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>4 months</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 <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 <b>April 4, 1960</b> to <b>April 11, 1960</b> and last saw her <sup>her</sup> alive on <b>April 11, 1960</b> Death occurred at <b>10:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>John T. Santoro, M.D.</b>				22b. ADDRESS <b>634 N. Grand Blvd.</b>			22c. DATE SIGNED <b>Apr. 12, 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 13, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo</b>		
24. FUNERAL DIRECTOR <b>Miceli &amp; Sons 1150 N. Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>APR 12 1960</b>		26. REGISTRAR'S SIGNATURE <b>Leah 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

*Anthony J. Mucci*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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