

RI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960

318

1003

-60-031983

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **7894**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2143a Maury Ave.		d. STREET ADDRESS (If outside, give location) 2143a Maury Ave.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARY Middle CAGNA Last CAGNA			4. DATE OF DEATH Month Aug. Day 7 Year 1960			
--	--	--	---	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-12-1883	9. AGE (last birthday) 77	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) New Mexico	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	---	--

13a. FATHER'S NAME Jacob Zelle	13b. MOTHER'S MAIDEN NAME Lucy Isma	14. NAME OF HUSBAND OR WIFE Late Peter Cagna
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 499-26-9658a	17. INFORMANT John P. Cagna 2143a Maury Ave.
---	--	--

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 1 wk. 10 yrs 11-
IMMEDIATE CAUSE (a) Cerebral Hemorrhage		
DUE TO (b) Hypertension		
DUE TO (c) Arteriosclerosis		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		331x	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 **June 1947** to **Aug 7, 1960** and last saw her ^{her} alive on **Aug. 7, 1960**
Death occurred at **5:50 P.** on the date stated above, and to the best of my knowledge, from the causes stated

22a. SIGNATURE Darlene J. Johnson M.D.	(Degree or title)	22b. ADDRESS 6400 Morganford	22c. DATE SIGNED 8-9-60
--	-------------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 11, 1960	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	-----------------------------------	--	---

24. FUNERAL DIRECTOR Kriegshausler 4228 S. Kingshighway Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. AUG 10 1960	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.
---	---------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M 86

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed William B. White

Licensed Embalmer No. 429

P. O. Address 4228 Kings

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