URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1960

-60-032662
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8573

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b: 50 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VET ADM HOSPITAL
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5136 DELMAR BOULEVARD
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: JOHN Middle: Last: MUTO
4. DATE OF DEATH: Month, Day, Year: AUGUST 30, 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married [ ] Never Married [ ] Widowed [ ] Divorced [X]
8. DATE OF BIRTH: 11-30-95
9. AGE (last birthday): 64
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): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (City and state or country): BEAVER FALLS, PA.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: MICHAEL MUTO
13b. MOTHER'S MAIDEN NAME: CAROLINE PELLAGRINI
14. NAME OF HUSBAND OR WIFE: UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Address: Hospital Records 915 N. Grand

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CARCINOMA OF PHARYNX — 1½ YEARS
DUE TO (c): 148x
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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 7-11-60, to 8-30-60 and last saw him alive on 8-30-60
Death occurred at 11:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): DR. SANFORD WOLFSON M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 8/31/60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 9/2/60
23c. NAME OF CEMETERY OR CREMATORY: National Cem.
23d. LOCATION (City, town, or county) (State): Jefferson Bks. Mo

24. FUNERAL DIRECTOR ADDRESS: Edward Fendler 5611 South Grand Blvd.
25. DATE RECD. BY LOCAL REG.: SEP 1 1960
26. REGISTRAR'S SIGNATURE: [illegible] Smith, M.D.

DOCUMENT 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_____ Signed George W Davolt.

Signature of Student Embalmer

Licensed Embalmer No. 4799

P. O. Address St. Louis,

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