

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8402 - 61-034125  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

**FILED SEP 18 1961**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS Length of stay in 1b 30 DAYS  
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BETHESDA HOSPITAL Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE MO b. COUNTY ST LOUIS  
c. CITY OR TOWN CREVE COEUR Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) 11745 OLD BALLAS RD. Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year  
ANTONIO CARAFFA 9 8 61

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 6-13-1878 9. AGE (last birthday) 83 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) SHOE REPAIR MAN 10b. KIND OF BUSINESS OR INDUSTRY RETIRED 11. BIRTHPLACE (City and state or country) ITALY 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME ANGELO CARAFFA 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE ANNA CARAFFA

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. NONE 17. INFORMANT Address FRANCIS O'NEILL 11745 OLD BALLAS RD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Terminal pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 days  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) encephalomalacia  
DUE TO (c) arteriosclerotic vasculodis

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. 332X  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  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. I attended the deceased from Aug 19 61 to Sept 1961 last saw her/him alive on Sept 2 1961  
Death occurred at Sept 8 '61 5 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Clarence L. Clark MD 22b. ADDRESS 530 New Ballas Rd 22c. DATE SIGNED 9/14/61

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 9-11-61 23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES 23d. LOCATION (City, town, or county) (State) ST LOUIS CO MO

24. FUNERAL DIRECTOR ADDRESS Earl Hillemann Overland 14 MO 25. DATE RECD. BY LOCAL REG. SEP 9 1961 26. REGISTRAR'S SIGNATURE Neal Smith MD

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Carl J. Hillman

Licensed Embalmer No. 3501

P. O. Address Orland 14 MI

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.