

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

12258

-61-046327

STATE FILE NUMBER

AMENDED

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

**FILED JAN 11 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5418 Bates St.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond W. Giudicy, Jr.</b>	4. DATE OF DEATH Month Day Year <b>Dec. 27, 1961</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1956</b>	9. AGE (last birthday) <b>5</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Raymond W. Giudicy</b>	13b. MOTHER'S MAIDEN NAME <b>Patricia Hill</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>none</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>St. Louis, Mo. Raymond W. Giudicy 5418 Bates</b>
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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>Subdural Hemorrhage from fractured skull</b> <b>suffered when struck by car operated by one, D. Juliette Daving, in front of about 4525 Eichberger, on Dec. 24<sup>th</sup>, 1961 at about 3:25 P.M.</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>accident</b>		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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>See above</b>
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20c. TIME OF INJURY Hour a.m. p.m. <b>4:45 p.m.</b>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>15<sup>th</sup> street</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>	COUNTY	STATE
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21. I attended the deceased from **445 p.m.** to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_

Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <b>Joseph M. ...</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>12-29-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>12-30-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 29 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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STATE AMENDED

DOCUMENT

SHOULD READ

ITEM NO.

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 me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed David Van Fossan

Licensed Embalmer No. 4242

P. O. Address St. Louis Mo

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.