

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028394

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7539

FILED AUG 13 1962

1. PLACE OF DEATH a. COUNTY		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>		c. CITY OR TOWN <b>St. Louis</b>	
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 <b>D.O.A. City Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1026 Tamm Ave.</b>	
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 <b>MARY</b> Middle Last <b>ANTONUCCI</b>			4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1962</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>10-21-1894</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------	-------------------------------------	-------------------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
-----------------------------------------------------------------------------------------------------------------	-----------------------------------------------------	------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <b>Nicholas DeRienzo</b>	13b. MOTHER'S MAIDEN NAME <b>Maria Maglione</b>	14. NAME OF HUSBAND OR WIFE <b>Late Frank Antonucci</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>None</b>	17. INFORMANT <b>Anthony Antonucci 1026 Tamm Ave.</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>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>260X</b>		

DUE TO (c)	
------------	--

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 \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Paul J. Simon</i> (Degree or title) <b>Deputy Coroner</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>8/1/62</b> (State)
--------------------------------------------------------------------------------	-----------------------------------	----------------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 3, 1962</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>Kriegshauser 4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 1 1962</b>	26. REGISTRAR'S SIGNATURE <i>Roan Smith M.D.</i>
------------------------------------------------------------------------	---------------------------------------------------	-----------------------------------------------------

VS 300 Rev. 4/59

1

2 *204*

3

4 *1*

5 *2*

6

7 *2*

8 *2*

9

10

11

12 *292-3*

13

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

STATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

91

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF CALIFORNIA

*[Faint handwritten text]*

**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 *James R. Dunn*

Licensed Embalmer No. 4527

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

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.