

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

7873162-032793
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED AUG 22 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|---|--|--|--|----------------------------------|--|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri. | | Length of stay in 1b | | 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 <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5232 Elizabeth Avenue. | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last George Pirone Sr. | | | 4. DATE OF DEATH Month Day Year August 10, 1962 | | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 1/5/1890 | | 9. AGE (last birthday) 72 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant | | | | 10b. KIND OF BUSINESS OR INDUSTRY Restuarant | | | | 11. BIRTHPLACE (City and state or country) Italy | | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | | | |
| 13a. FATHER'S NAME Batista Pirone | | | | 13b. MOTHER'S MAIDEN NAME Domenica Barrieio | | | | 14. NAME OF HUSBAND OR WIFE Mary Pirone | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mary Pirone, 5232 Elizabeth Avenue. | | | | Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from Gastric Ulcer | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 540.0 | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis | | | | | | | | 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 14 July 58 to 10 Aug 62 and last saw him alive on 9 Aug 62 Death occurred at 2:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) John McLean M.D. | | | | | | 22b. ADDRESS 4401 Hampton | | | | 22c. DATE SIGNED 10 Aug 62 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 8/13/62 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Calcaterra Funeral Home, 5140 Daggett Ave. | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. AUG 11 1962 | | 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. | | | | | | | | | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

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 Robert M. Murray

Licensed Embalmer No. 3749

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.