

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003496

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1121 STATE FILE NUMBER

FILED FEB 8 1963

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis, Missouri</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis, Missouri</u> | | Length of stay in 1b <u>4 days</u> | | c. CITY OR TOWN <u>University City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hamilton Medical Center</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>7055 Amherst</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>M.</u> Last <u>Giarraffa</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>1963</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 30 1889</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hay Day Shoe Co.</u> | | 11. BIRTHPLACE (City and state or country) <u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A. Naturalized</u> | | 13a. FATHER'S NAME <u>Dominic Giarraffa</u> | | 13b. MOTHER'S MAIDEN NAME <u>Josephine Popania</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Single</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Antonina Mercurio 7055 Amherst</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>331x</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>A.S.H.D</u> | | | | 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. | | 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 <u>3-14-58</u> to <u>1-31-63</u> and last saw him alive on <u>1-31-63</u> Death occurred at <u>9:00 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>R. P. Hayden M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>730. Hadimouth</u> | | 22c. DATE SIGNED <u>2-1-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>2-4-63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser West 9450 Olive Blvd.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>FEB 2 1963</u> | | 26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u> |

USE BLACK INK OR TYPEWRITER RIBBON

86

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 William C. White

Licensed Embalmer No. 4791

P. O. Address 4228 De Keyser Highway

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.