

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008514

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1921

STATE FILE NUMBER

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DATE AMENDED
Rev. 4/59	
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60	DOCUMENT
USE BLACK INK OR TYPEWRITER RIBBON	MEDICAL CERTIFICATION
ITEM NO.	BY AFFIDAVIT OF
SHOULD READ	

1. PLACE OF DEATH -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <b>Mo.</b>	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only). <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>40 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5400 Tennessee Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED			4. DATE OF DEATH
First Middle Last <b>LOUIS DeBIASI</b>			Month Day Year <b>February 20 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</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>10/15/1905</b>
9. AGE (last birthday) <b>57</b>		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) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Maker</b>	11. BIRTHPLACE (City and state or country) <b>Iowa</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Frank DeBiasi</b>	
13b. MOTHER'S MAIDEN NAME <b>Angela (last name unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>None</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. [REDACTED]	
17. INFORMANT <b>Gino Mariani</b>		Address <b>5029 Bancroft Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line)			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>			<b>2 days</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>			
DUE TO (c) <b>4200</b>			
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>2-18-63</b> to <b>2-20-63</b> and last saw him alive on <b>2-20-63</b> Death occurred at <b>Faith Hospital</b> <b>2<sup>30</sup>p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree, or title) <b>Albert Kaplan M.D.</b>		22b. ADDRESS <b>4385 Maryland</b>	22c. DATE SIGNED <b>2-21-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 22, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>
24. FUNERAL DIRECTOR <b>Arthur J. Donnell</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 21 1963</b>	26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>
ADDRESS <b>3840 Lindell Blvd.</b>			

**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

*Francis Williamson*

Licensed Embalmer No.

*3565*

P. O. Address

*3840 Lindell*

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.