

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009755

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 585 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 5 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>St. Louis</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grantwood</u> Length of stay in 1b <u>5 Yrs.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9020 Whitehaven</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u></p> <p>c. CITY OR TOWN <u>Grantwood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>9020 Whitehaven</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First Middle Last <u>COSTANTINO DiFRANCO</u></p>	
<p>4. DATE OF DEATH Month Day Year <u>Feb. 20 1963</u></p>	
<p>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u></p> <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>5-9-1877</u> 9. AGE (last birthday) <u>85</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Building & Real Estate Operator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Building & Real Estate Operator</u></p>	
<p>11. BIRTHPLACE (City and state or country) <u>Augusta, Italy</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>Carmelo DiFranco</u> 13b. MOTHER'S MAIDEN NAME <u>Carmela Caramagno</u> 14. NAME OF HUSBAND OR WIFE <u>Late Carmela DiFranco</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Carmen DiFranco</u> Address <u>5607 Hampton Ave.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Edema</u></p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____</p> <p>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</p>	
<p>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.) _____</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year _____</p>	
<p>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 _____</p>	
<p>21. I attended the deceased from <u>December, 1962</u> to <u>February 1963</u> and last saw him alive on <u>2-20-63</u> 10:15 A. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Paul Rosenberg D.O.</u> 22b. ADDRESS <u>9302 Gravois</u> 22c. DATE SIGNED <u>2-21-63</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>Feb. 23, 1963</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u> 23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u> (State) _____</p>	
<p>24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway Blvd.</u> 25. DATE RECD. BY LOCAL REG. <u>2-21-63</u> 26. REGISTRAR'S SIGNATURE <u>John Murphy M.D.</u></p>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev: 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

Dr. Paul Rosenberg
9302 Grevolds

FL. 1-9944

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 Edwin A. McDevitt

Licensed Embalmer No. 3024

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.