

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

#63-014321
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **FILED APR 7 1963** Registration District No. **500** Registrar's No. **876**

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | |
|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY - - - | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b 3 years | 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 Gravois Rest Haven | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6049 Arthur | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Marie (n.m.i.) Nardi | | | 4. DATE OF DEATH Month Day Year March 11, 1963 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-12-80 | 9. AGE (last birthday) 82 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (City and state or country) Italy | 12. CITIZEN OF WHAT COUNTRY Italy | | |
| 13a. FATHER'S NAME (Unknown) Dulpo | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE John Pretto, Joseph Zarontonello, Romeo Nardi | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Michael Pretto 7529 Big Bend | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia | | | | | | INTERVAL BETWEEN ONSET, AND DEATH 5 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) | | | DUE TO (c) 4912 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio-Sclerotic-Cardio-Vascular Disease @ Chronic Brain Syndrome | | | | 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"/> | NONE | 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 5-30-60 to 3-11-63 and last saw her alive on 3-10-63 Death occurred at 135 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) Allen M. Kearney M.D. | | | 22b. ADDRESS 860 N Woodlawn | | 22c. DATE SIGNED 3-12-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-13-63 | 23c. NAME OF CEMETERY OR CREMATORY Restoration Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa | | 25. DATE RECD. BY LOCAL REG. SAM 3-12-63 | 26. REGISTRAR'S SIGNATURE John B. Murphy 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 Bill C. Branson

Licensed Embalmer No. 4764

P. O. Address St Louis

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.