

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-017974

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4667** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

FILED MAY 2 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 6 days	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 Missouri Baptist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2515 St. Louis Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Catherine Mocer			4. DATE OF DEATH Month Day Year April 27 1963		
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5. SEX Female	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 5/4/1883	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months 11 Days 23 Hours Min. 	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Italy	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Frank Guccione	13b. MOTHER'S MAIDEN NAME Angela Greco	14. NAME OF HUSBAND OR WIFE Angelo
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mr. Nick Mocer 9475 Yorktown Drive
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cleal obstruct in due to adhesions		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) bands	
	DUE TO (c) 570.5	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Paralysis agitans for years		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
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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.)
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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
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21. I attended the deceased from 8-10-62 to 4-27-63 and last saw her ^{her} _{him} alive on 4-27-63 Death occurred at 9:10 PM 4-27-63 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dr. Norman Bailey M.D.	22b. ADDRESS 6356 Clayton Rd. St. Louis, Mo.	22c. DATE SIGNED 4-24-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/1/63	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) St. Louis, Missouri
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24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd	25. DATE RECD. BY LOCAL REG. APR 29 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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USE BLACK INK OR TYPEWRITER RIBBON

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Dr. Beaman Bailey
6356 Clayton Rd.
Mil 7-3834 - 1 to 6
Mo - 5-6692 Daily

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.