

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029927

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8155

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 15 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 18 hours		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 4335 Shaw Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nicholas W. Florito			4. DATE OF DEATH Month Day Year August 9 1963			5. SEX Male		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 3/8/1909		9. AGE (last birthday) 54		IF UNDER 1 YEAR Months Days Hours Min. 3 1 1		IF UNDER 24 HR Hours Min. 1 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner			10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo			11. BIRTHPLACE (City and state or country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Calarago (Kelly) Florito			13b. MOTHER'S MAIDEN NAME Augusta Molly Hemm			14. NAME OF HUSBAND OR WIFE Erma Florita					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs. Erma Florito 4335 Shaw Avenue					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) 331X INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 YEARS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DISEASE							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. 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 OCT. 1961 to AUG. 1963 and last saw ^{from} him ^{alive} on 7/11/63 . Death occurred at 11:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Maxton A. Binder M.D.				22b. ADDRESS 4652 Maryland				22c. DATE SIGNED 8/10/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/12/63		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri					
24. FUNERAL DIRECTOR Arthur J. Donnelly 3840 Lindell Blvd				25. DATE RECD. BY LOCAL REG. AUG 10 1963		26. REGISTRAR'S SIGNATURE Earl Smith M.D.					

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT
 VS 300 Rev. 4/59
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 12 **75-0**
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 DATE AMENDED **8-16-63**
 SHOULD READ **493-07-8360**
 BY AFFIDAVIT OF **Maxton A. Binder**

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 Wm. S. L. [Signature]

Licensed Embalmer No. 4699

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.