

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-045967**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11319 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF
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USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

FILED NOV 22 1963					
1. PLACE OF DEATH					
a. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) Length of stay in 1b					
OR TOWN <u>St. Louis</u>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5235 Bancroft Ave.</u>					
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. STATE <u>Missouri</u> b. COUNTY					
c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. STREET ADDRESS (If outside, give location) <u>5235 Bancroft Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last <u>JoAnn Roncatto</u>			Month Day Year <u>November 11, 1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1888</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	Months Days Hours Min.
13a. FATHER'S NAME <u>Anthony Gay</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Michael Roncatto</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>4201</u>		17. INFORMANT Address <u>Mary Lewis, 5235 Bancroft Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line)					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>					<u>5 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>					<u>12 years</u>
DUE TO (c) <u>vascular disease</u>					
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 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"/>	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 <u>1951</u> to <u>11/14/63</u> and last saw her/him alive on <u>11/9/63</u>		Death occurred at <u>11:30 am 11/14/63</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John J. Murrelly M.D.</u>		22b. ADDRESS <u>6400 Chippewa</u>		22c. DATE SIGNED <u>11/14/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-16-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richardsdale</u>		23d. LOCATION (City, town, or county) (State) <u>Bever, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hopps, Inc., 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV-15 1963</u>		26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>	

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
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 \_\_\_\_\_

**STATEMENT BY LICENSED EMBALMER**

Signed James Dinkley  
Licensed Embalmer No. 3653  
P. O. Address J. Dinkley

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.

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