

S. No. 300
V. 10.48

FILED JUN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17949

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4945

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY OR TOWN <u>St. Louis, Missouri</u>	c. LENGTH OF STAY (In this place) <u>5 Mos. 4 Days</u>	c. CITY OR TOWN <u>215 S. 3rd. Street</u>	<u>25</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Infirmary Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>(75) 215 S. 3rd., Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) _____ c. (Last) <u>Astorino</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 3, 1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/11/1863</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>23</u> Days _____ Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Knife Grinder</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

13a. FATHER'S NAME <u>Thomas Astorino</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Teresa Astorino</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Teresa Astorino</u>	ADDRESS <u>215 S. 3rd., Street</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>44BX</u>

22. I hereby certify that I attended the deceased from Dec. 29, 1949, to June 3, 1950, that I last saw the deceased alive on June 3, 1950, and that death occurred at 1:23:35 am., from the causes and on the date stated above.

23a. SIGNATURE <u>Celia Hrag, M.D.</u>	(Degree or title)	23b. ADDRESS <u>5600 Arsenal St. Louis</u>	23c. DATE SIGNED <u>3 June 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 7, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JUN 5 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Lanter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>White & Donnelly</u>	ADDRESS <u>3840 Lindell Blvd.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

W H Van Matre

Signed.....

Student Embalmer

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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 this body is not embalmed, fact should be so stated above.