

STANDARD CERTIFICATE OF DEATH

State File No. **24925**
 Registrar's No. **5829**

FILED JUL 16 1951

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Collinsville 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) Rural Route 18	
3. NAME OF DECEASED a. (First) Sam b. (Middle) NMN c. (Last) LOCANDRO			4. DATE OF DEATH (Month) (Day) (Year) July 1 1951
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH AUGUST 3, 1878
9. AGE (Last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY COAL MINE	
11. BIRTHPLACE (State or foreign country) CITTA NOVA, ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joseph Locandro		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE CORNELIA LOCANDRO		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. 332-07-8688		17. INFORMANT'S SIGNATURE OR NAME CORNELIA LOCANDRO - COLLINSVILLE	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of esophagus ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>		21a. ACCIDENT (Specify) SUICIDE HOMICIDE	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 130X		22. I hereby certify that I attended the deceased from June 22, 1951 , to July 1, 1951 , that I last saw the deceased alive on July 1, 1951 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) FR Bradley MD		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 7-1-51		24a. BURIAL - CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 7-1-51		24c. NAME OF CEMETERY OR CREMATORY SS. Peter + PAUL	
24d. LOCATION (City, town, or county) (State) Collinsville ILL		25. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hasey - Collinsville	
DATE REC'D BY LOCAL REG. JUL 1 - 1951		REGISTRAR'S SIGNATURE J.B. Lester	

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 the certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Herbert A. Kassly*

Licensed Embalmer No. *72803*

P. O. Address *Callanville 20*

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.