

FILED OCT 4 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33527

State File No. ....

8979

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		<b>2059</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospt.</b>				d. STREET ADDRESS (If rural, give location) <b>1064 Hamilton Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Joseph Vasirani</b>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 25 1952</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>		8. DATE OF BIRTH <b>Aug. 15 1888</b>	
9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Cement worker</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Casino, Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>5</b>
13a. FATHER'S NAME <b>Francisco Vasirani</b>			13b. MOTHER'S MAIDEN NAME <b>Dont Know</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes # 1</b>			16. SOCIAL SECURITY NO. <b>Dont Know</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Peter Ross</b> ADDRESS <b>6227 Plymouth Ave</b>		
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) <b>Cancer of Stomach</b>  ANTECEDENT CAUSES Morbid 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.  INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS.</b>					
19a. DATE OF OPERATION <b>8-1-52</b>		19b. MAJOR FINDINGS OF OPERATION <b>CANCER of Stomach with metastases.</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>151X</b>			
22. I hereby certify that I attended the deceased from <b>8-1</b> , 19 <b>52</b> , to <b>9-25</b> , 19 <b>52</b> , that I last saw the deceased alive on <b>9-25</b> , 19 <b>52</b> , and that death occurred at <b>4 P. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>John Charles Doucek, Jr. M.D.</b> (Degree or title)			23b. ADDRESS <b>1233 Laven Del - Kirkwood Mo.</b>			23c. DATE SIGNED <b>9/26/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Sept 27 1952</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 26 1952</b>		REGISTRAR'S SIGNATURE <b>J. Charles Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. W. Clark</b> ADDRESS <b>1125 Hadjiment Ave.</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. F. McCann  
4383 Westminster Pl.  
Fr. 3033

*W. Decker*  
*H. Jerome Hoyt*

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 .....  
Student Embalmer

Signed *John J. Haines*  
Licensed Embalmer No. *4108*

P. O. Address *St Louis MO*

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.