

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015485

STATE FILE NUMBER

FILED APR 18 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

4017

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. #1</u>			Length of stay in lb <u>222</u>		d. STREET ADDRESS (If outside, give location) <u>2646 Rutger Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ivan</u> Last <u>Antonich</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>10</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 24 1879</u>		9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (City and state or country) <u>Jugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		
13a. FATHER'S NAME <u>John Antonich</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Antonich</u>			14. NAME OF HUSBAND OR WIFE <u>Mary</u>			
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.		17. INFORMANT Address <u>Mary Antonich 2646 Rutger Street</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vasculae accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>33ix</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 mos. years.</u>		
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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT <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>2-20-58</u> , to <u>4-10-58</u> and last saw him <u>him</u> alive on <u>4-10-58</u> Death occurred at <u>7:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Leo V. Mulligan M.D.</u>				22b. ADDRESS <u>1515 Lafayette</u>				22c. DATE SIGNED <u>4-10-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/14/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>S S Peter & Paul Cem</u>			23d. LOCATION (City, town, or county) (State) <u>St Louis Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Moydell Funeral Home 1926 Allen</u>				25. DATE RECD. BY LOCAL REG. <u>APR 11 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u>			

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 *Reinhold K. Lehmann*

Licensed Embalmer No. *3395*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.