

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041391

STATE FILE NUMBER

11204

FILED DEC 9 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAINT LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SAINT LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		Length of stay in lb LIFE 2	d. STREET ADDRESS (If outside, give location) 69 4822 PALM STREET

3. NAME OF DECEASED (Type or print) First Middle Last Annie Stella Marie Cassin			4. DATE OF DEATH Month Day Year Nov. 17 1958		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1876	9. AGE (In years last birthday) 82 yrs	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	-------------------------------------

13a. FATHER'S NAME Joseph Dvorak	13b. MOTHER'S MAIDEN NAME Mary Unknown	14. NAME OF HUSBAND OR WIFE Mr. Bernard Cassin
-------------------------------------	---	---

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. Unknown	17. INFORMANT Address Mr. Bernard Cassin, 4822 Palm St., 15
---	------------------------------------	--

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 Embolus</u>		INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) <u>Ventricular Fibrillation</u>	12 days
	DUE TO (c) <u>Atherosclerotic heart disease</u>	14 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) 420.0		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 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>1940</u> to <u>Nov 17 1958</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>Nov 17 1958</u> Death occurred at <u>8:25 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) <u>Dr. C. N. Leiseman M.D.</u>	22b. ADDRESS <u>4126 S. Shrew Ave</u>	22c. DATE SIGNED <u>11/20/58</u>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/21/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri.</u>
--	------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>CALVIN F. FEUTZ, 4828 NAT'L BRIDGE BLVD.</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 20 58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> <u>m &amp; B.</u>
---	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

10-2 daily except Wednesday  
407 Mon. & Thurs.

File in city

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 *John A. M. Lewis* .....

Licensed Embalmer No. *4186* .....

P. O. Address *St. Louis* .....

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.