

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002501

STATE FILE NUMBER

FILED FEB 6 1959

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 23

300
1-57

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) Moberly		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Moberly Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Woodland Hospital		Length of stay in lb 34 Yrs.	d. STREET ADDRESS (If outside, give location) 511 Fort St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last GASPAROTTI			4. DATE OF DEATH Month JAN. Day 27 Year 1959
5. SEX Male	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 Feb. 3, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Refrigeration Engineer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years from birthday) 63
11. BIRTHPLACE (City and state or country) Collinsville, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John B. Gasparotti		13b. MOTHER'S MAIDEN NAME ?	14. NAME OF HUSBAND OR WIFE Elizabeth
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 491-07-0151	17. INFORMANT Mrs. Elizabeth Gasparotti Address Moberly
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from left cerebral artery			INTERVAL BETWEEN ONSET AND DEATH 15 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis			14 years
DUE TO (c) Previous apoplexy with right hemiplegic			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3314			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2.
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 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 Sept. 2, 1955 to Jan. 27, 1959 and last saw her/him alive on Jan. 27, 1959 Death occurred at 3:15 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Clarence C. Coburn M.D. (Degree or title)		22b. ADDRESS 17 Virginia Ave., Moberly, Mo.	22c. DATE SIGNED Jan. 27, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 30, 1959	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR Mahan Funeral Service ADDRESS Moberly		25. DATE RECD. BY LOCAL REG. 1-30-59	REGISTRAR'S SIGNATURE Leah... ..

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

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FEB 20 1959

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. Green*

Licensed Embalmer No. 3815

P. O. Address *Mt. Kenya, 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.