

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003361  
STATE FILE NUMBER  
Registrar's 1038

FILED FEB 10 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>West Frankfort</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b <u>5 Days</u>	d. STREET ADDRESS (If outside, give location) <u>505 S. MAPLE</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK NMN PASQUINO</u>			4. DATE OF DEATH Month Day Year <u>JANUARY 28, 1959</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>Oct 8 - 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	9. AGE (In years) Last birthday Months Days Hours Min. <u>78</u>
11. BIRTHPLACE (City and state or country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>BERNADETTE</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>357-10-4632</u>	17. INFORMANT Address <u>Mrs FRANK PASQUINO west Frankfort ILL</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>INFARCTION OF LUNG</u> DUE TO (b) <u>PULMONARY EMBOLUS, ETIOLOGY UNKNOWN</u> DUE TO (c) <u>465XG</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SEVERE ANTHROSILICOSIS OF LUNGS CHRONIC PYELONEPHRITIS DUODENAL ULCER</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</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 o.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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>JAN. 23, 1959</u> to <u>JAN. 28, 1959</u> and last saw her/him alive on <u>JAN. 28, 1959</u> Death occurred at <u>3:00 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>C. D. Vermillion, M.D.</u> M. D.		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>West Frankfort ILL</u>
24. FUNERAL DIRECTOR <u>Union</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 29 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Frank Proff* .....

Licensed Embalmer No. *4356* .....

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.