THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007354

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1639

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. — Length of stay in lb 3 weeks	d. STREET ADDRESS (If outside, give location) 5955 Wabada — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Joseph	Middle	Last Leveroni ~~Lavaroni~~	4. DATE OF DEATH Month Day Year 2-13-59
5. SEX male	6. COLOR OR RACE white	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Nov. 1 ~~1884~~ 1891
9. AGE (In years last birthday) ~~74~~ 67	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) Cook	10b. KIND OF BUSINESS OR INDUSTRY Resturant	11. BIRTHPLACE (City and state or country) Italy 5	12. CITIZEN OF WHAT COUNTRY? Italy
13a. FATHER'S NAME John	13b. MOTHER'S MAIDEN NAME Louisa	14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 500-30-5372	17. INFORMANT Matilda Cassino — Address 5955 Wabada	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 3 mks.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) 420.0

DUE TO (c) Generalized Arteriosclerosis — 3 mks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

ITEM 3, 8, 9 3-20-59 CORRECTED
BY: 1. AFFIDAVIT OF Informant
2. DOCUMENT Metropolitan Ins. Co. Policy # 379-400 C dated 1-1922

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-21-59, to 2-13-59 and last saw her/him alive on 2-13-59

Death occurred at 4:45 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 2/13/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Mousaleum	23b. DATE Feb. 16, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
24. FUNERAL DIRECTOR Miceli — ADDRESS 1150 No. Kingshighway	25. DATE RECD. BY LOCAL REG. FEB 16 '59	26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.