

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011793
STATE FILE NUMBER

APR 6 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 900

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Florissant		c. CITY OR TOWN Florissant 4051	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 St. Eugene La.		d. STREET ADDRESS (If outside, give location) 35 St. Eugene Lane	
3. NAME OF DECEASED (Type or print) First Steve Middle Vidusich Last Vidusich		4. DATE OF DEATH Month 3 Day 30 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-5-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair	11. BIRTHPLACE (City and state or country) Valpavo, Ugoslavia
13a. FATHER'S NAME Lawrence Vidusich		13b. MOTHER'S MAIDEN NAME Lena Unknown	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) No None		16. SOCIAL SECURITY NO. 498-09-1698	17. INFORMANT Address Ann Sorrell 35 St. Eugene La, Florissant
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of Liver - Metastases DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1561			INTERVAL BETWEEN ONSET AND DEATH
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.) Clinic Patient Barnes Hospital Referred to me for Home Call.		20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 3-30-59 to 3-31-59 and last saw her/him alive on 3-31-59 . Death occurred at 10:00 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE William H. Davis M.D.		22b. ADDRESS 3121 N. Grand	22c. DATE SIGNED 4-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-3-59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR White-Mullon 118 N. Florissant Rd.		25. DATE RECD. BY LOCAL REG. 4-2-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

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
MEDICAL CERTIFICATION

3121

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 *Richard K. Korman*

Licensed Embalmer No. *3395*
P. O. Address *St. Louis 21 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.