

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-01914
STATE FILE NUMBER
2 4756
Registration No.

FILED JUN 1 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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 724 S. Newstead	
Length of stay in 1b D.O.A.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES A. CAESER			4. DATE OF DEATH Month Day Year May 14 1959			
-------------------------------------------------------------------------------	--	--	---------------------------------------------------	--	--	--

5. SEX Male <input checked="" type="radio"/>	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 Oct. 1, 1887	9. AGE (In years last birthday) 71	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) Painting Contractor (Retired)	10b. KIND OF BUSINESS OR INDUSTRY (Retired)	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------	--------------------------------------------------------------	----------------------------------------

13a. FATHER'S NAME Charles Caesar	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Clara S. Caesar
--------------------------------------	--------------------------------------	------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give type and dates of service) No None	16. SOCIAL SECURITY NO. 497-09-5185	17. INFORMANT Clara S. Caesar 724 S. Newstead	Address
------------------------------------------------------------------------------------------------------------------------	----------------------------------------	--------------------------------------------------	---------

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>Coronary occlusion acute</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Arteritis generalis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		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 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 Death occurred at <u>April 20, 1959</u> to <u>May 14, 1959</u> and last saw him alive on <u>May 6, 1959</u> 9:50 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dominic J. Verducci M.D.</u>	22b. ADDRESS <u>4500 Olive</u>	22c. DATE SIGNED <u>5-15-59</u>
---------------------------------------------------------------------	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 18, 1959	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
------------------------------------------------------	---------------------------	-----------------------------------------------------	--------------------------------------------------------------------

24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. MAY 15 '59	26. REGISTRAR'S SIGNATURE <u>W. Smith, M.D.</u>
-----------------------------------------------------------	--------------------------------------------	----------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

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 *Edwin A. McSweeney*

Licensed Embalmer No. *3024*.....

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.