

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019474

STATE FILE NUMBER
2 5300

Health,
Welfare
Public
Service

REGD JUN 15 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300
1-57

54
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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 checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1715 Hickory		d. STREET ADDRESS (If outside, give location) 1715 Hickory	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHERMAN Middle Last NASSIF			4. DATE OF DEATH Month June Day 1 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 April 15, 1905
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distribution Dept. Freund Bakery	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hawash Nassif	
13b. MOTHER'S MAIDEN NAME Hanna Khoury		14. NAME OF HUSBAND OR WIFE Estella Nassif	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-05-7139	
17. INFORMANT Estella Nassif		Address 1715 Hickory	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung			INTERVAL BETWEEN ONSET AND DEATH 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			163x
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.) 2-2-59	
20f. CITY, TOWN, OR LOCATION 6-1-59		COUNTY STATE	
21. I attended the deceased from Feb 2 1959 to June 1 1959 and last saw ^{her} him alive on 5/31/59 Death occurred at 3:50 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Frank Swekosky (Degree or title) Frank Swekosky MD		22b. ADDRESS 4045 So Grand 4045 So Grand	
22c. DATE SIGNED 6/1/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 3, 1959	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem		23d. LOCATION (City, town, or country) (State) St. Louis Co Mo.	
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. JUN 2 '59	
26. REGISTRAR'S SIGNATURE Loal Smith, M.D.			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature of ICD-9. No symptoms with no stated.

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address Jennings

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.