

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025691

FILED VS AUG 14 1959 59

Registration District No. \_\_\_\_\_ Primary Registration District No. 5591 Registrar's No. 53

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST. LOUIS</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HILLSBORO</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS CO.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CASTLE ACRES NURS Home</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6448 HIGHFIELD</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>-</b> Last <b>CASARAGHI</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>1959</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>SEPARATED</b>		8. DATE OF BIRTH <b>JAN 24 1888</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REI. TERRAZZO WORKER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ANTHONY CASARAGHI</b>			13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE POZZI</b>			14. NAME OF HUSBAND OR WIFE <b>UNK.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>NORMAN CASARAGHI</b>			Address <b>6448 HYFIELD ST. LOUIS, CO., MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcoma of femur</b> DUE TO (b) <b>E gen. Metastasis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>Jan 59.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m. <b>no</b>	Month, Day, Year	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 <b>Jan, 1959</b> to <b>July 31, 59</b> and last saw him alive on <b>July 29, 59</b> Death occurred at <b>11 sep</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Norm V. Hoffmister M.D.</b>			22b. ADDRESS <b>Desart, Mo.</b>			22c. DATE SIGNED <b>Aug 1, 59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>AUG 3 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION</b>			23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CO Mo.</b>			
24. FUNERAL DIRECTOR <b>ALBERT H. HOPPE</b>			ADDRESS <b>ST. LOUIS MO.</b>		25. DATE RECD. BY LOCAL REG. <b>8-3-59</b>		26. REGISTRAR'S SIGNATURE <b>Oliver D. ...</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 14 1959

Karl V. McKinstry, M.D.  
DeSoto, Missouri

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald B. DeSoto

Licensed Embalmer No. 4104

P. O. Address DeSoto Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.