

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 30 1959

59-026478

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2,6741**

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			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5308 Devonshire Ave.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5308 Devonshire Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROSE(ROSI) Middle CAPONE Last				4. DATE OF DEATH Month July Day 18 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1882	9. AGE (last birthday) 76	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) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Andrew Sansone			13b. MOTHER'S MAIDEN NAME Josephine Unknown			14. NAME OF HUSBAND OR WIFE Late Joseph Capone	
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. None		17. INFORMANT Teresa Capone 5308 Devonshire Ave. 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) Permanental Uremia						INTERVAL BETWEEN ONSET AND DEATH 10 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized & nephrotic Sclerosis							
DUE TO (c) Stroke 594x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute & Chr. Osteoarthritis Deformans						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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. 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 1936 to 7/18/59 and last saw her alive on 7/17/59 Death occurred at 7:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Doctor or title) Walter H. Hofer				22b. ADDRESS 3108 S. Grand.		22c. DATE SIGNED 7/20/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 21, 1959		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway ADDRESS				25. DATE RECD. BY LOCAL REG. JUL 20 '59		26. REGISTRAR'S SIGNATURE Loan Smith, M.D. mde	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Edwin A. McArthur

Licensed Embalmer No. 3024

P. O. Address _____

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.