

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS NOV 12 1959**

**59-037381**

STATE FILE NUMBER

**210097**

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

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INCARNATE Word Hosp</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>1639 CALIFORNIA</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>J.</b> Last <b>ANTON</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>31</b> Year <b>1959</b>											
5. SEX <b>MAle</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-20-1898</b>		9. AGE (last birthday) <b>61</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____		IF UNDER 24 HR Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTING SUPERINTENDENT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>				11. BIRTHPLACE (City and state or country) <b>ALABAMA</b>				12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13a. FATHER'S NAME <b>JOSEPH ANTON</b>				13b. MOTHER'S MAIDEN NAME <b>Lottie ZENA</b>				14. NAME OF HUSBAND OR WIFE <b>Genevieve ANTON</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>No/No</b>				17. INFORMANT <b>Genevieve ANTON</b>				Address <b>1639 CALIFORNIA</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>myocardial infarction</b> DUE TO (b) <b>arteriosclerotic heart-disease</b> DUE TO (c) <b>advanced arteriosclerosis &amp; overweight</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <b>chronic bilateral nephritis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>  <b>years</b>  <b>"</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>ST. Louis</b>				COUNTY		STATE	
21. I attended the deceased from <b>May 55</b> to <b>October 31/59</b> and last saw him alive on <b>Oct 31/59</b> Death occurred at <b>the Incarnate Word hospital</b> on the date stated above, and to the best of my knowledge, from the causes stated. <b>11:25 P.M.</b>															
22a. SIGNATURE (Degree or title) <b>Maximilian Weitman M.D.</b>						22b. ADDRESS <b>3530 ARSENAL, St. Louis</b>				22c. DATE SIGNED <b>11-3-59.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV 4, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>S. S. PETER &amp; PAUL Cem</b>				23d. LOCATION (City, town, or county) (State) <b>ST. Louis Mo.</b>							
24. FUNERAL DIRECTOR <b>Thomas Lute 2906 Gravois</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>NOV 3 1959</b>		26. REGISTER'S SIGNATURE <b>Coal Smith M.D.</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**W.B.**

**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 Eleanora Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grove

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.