

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 2 5 2

FILED VS DEC 23 1959

211636

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|--|--|---|--|
| 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 | | Length of stay in 1b | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1709 Marconi | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1709 Marconi Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Angelo Middle Bolasina Last | | | 4. DATE OF DEATH Month December Day 14 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 5/29/1885 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Clay Products | 11. BIRTHPLACE (City and state or country) Italy | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Joseph Bolasina | | 13b. MOTHER'S MAIDEN NAME Anonciata Unknown | | 14. NAME OF HUSBAND OR WIFE Antoinette | |
| 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. 492-03-5579 | 17. INFORMANT Address Louis Bolasina, 1709 Marconi | | |

| | | |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) arterio sclerotic heart disease | 24. |
| | DUE TO (c) generalized arteriosclerosis | 24 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420-0 | | 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"/> | 20. 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 **11-20-59** to **12-14-59** and last saw him alive on **12-14-59**
Death occurred at **5** **A** m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|---|------------------------------|--|--|
| 22a. SIGNATURE (Degree or title) Charles Montani, M.D. | | 22b. ADDRESS 5147 Daggett Ave | 22c. DATE SIGNED 12-14-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-17-59 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Calcaterra Funeral Home, 5140 Daggett Ave. | | 25. DATE RECD. BY LOCAL REG. DEC 15 1959 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>mjs</i> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Embalmer

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Embalmer

December 12, 1958

Embalmer

Embalmer

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x

Embalmer

STATEMENT BY LICENSED EMBALMER

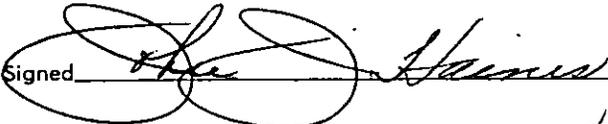
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4108

P. O. Address Haines

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.

Embalmer