

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS OCT 10 1960

60-036978  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2928

1. PLACE OF DEATH a. COUNTY <b>St. Louis</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>Normandy</b>		Length of stay in 1b <b>22 Days</b>		c. CITY OR TOWN <b>Jennings</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5645 Hodiament</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rudy</b> Middle <b>Marsanick</b> Last <b>Marsanick</b>				4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1960</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>12-16-1909</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Finisher</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>J. S. Alberici</b>		11. BIRTHPLACE (City and state or country) <b>Union Town, Penn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Marsanick, Lawrence</b>			13b. MOTHER'S MAIDEN NAME <b>, Josephine</b>			14. NAME OF HUSBAND OR WIFE <b>Hilda Marsanick</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>194 09 7815</b>		17. INFORMANT Address <b>Hilda Marsanick - 5645 Hodiament Ave.</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>ACUTE CARDIAC TAMPONADE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Rupture of ventricular aneurysm</b>							<b>instant</b>
DUE TO (c) <b>Acute myocardial infarction</b>							<b>19 days</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 <b>11:30</b> a.m. <b>11:30</b> p.m.		Month, Day, Year <b>9-13-60</b>	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.) <b>Calvary</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo.</b>		COUNTY <b>St. Louis</b>		STATE <b>Mo.</b>	
21. I attended the deceased from <b>9-13-60</b> to <b>10-5-60</b> and last saw her/him alive on <b>10-5-60</b> Death occurred at <b>11:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert W. Shelby DO</b>				22b. ADDRESS <b>7840 Natural Bridge Rd. (21)</b>		22c. DATE SIGNED <b>10-5-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/8/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Buchholz Mort, 5967 W. Florissant, Ave</b>			25. DATE RECD. BY LOCAL REG. <b>10-6-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>		

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 Wilford J. Beal

Licensed Embalmer No. 455

P. O. Address St. Louis

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