

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 19 1960

60-037001
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2665

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. John's</u>		c. CITY OR TOWN <u>St. John's</u>	
Length of stay in 1b <u>1 1/2 Yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3243 Marshall Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>3243 Marshall Ave.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>J.</u> Last <u>SANSONE</u>	4. DATE OF DEATH Month <u>Sep.</u> Day <u>7</u> Year <u>1960</u>
--	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	---	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber-Self Employed (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>(Retired)</u>	11. BIRTHPLACE (City and state or country) <u>Sicily, Italy</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>Carl Sansone</u>	13b. MOTHER'S MAIDEN NAME <u>Frances Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Sansone</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>499-01-4970a</u>	17. INFORMANT Address <u>Carl Sansone #45 Ballas Ct. (31)</u>
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, Hypertension, Cerebral</u>	<u>Arteriosclerosis</u>
DUE TO (c) <u>Arteriosclerosis</u>	<u>Arteriosclerosis</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrosclerosis</u>	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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u>

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 1957 to Sept 7, 1960 and last saw her him alive on Sept 7, 1960
Death occurred at 7:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph P. Estelle, M.D.</u>	22b. ADDRESS <u>4952 Mayland</u>	22c. DATE SIGNED <u>9/8/60</u>
---	----------------------------------	--------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-10-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 9450 Olive St. Road</u>	25. DATE RECD. BY LOCAL REG. <u>9-9-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>
--	--	---

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 E. J. McNeill

Licensed Embalmer No. 302

P. O. Address _____

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.