RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960 318 1003 11204 60-044331

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

DED

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis,
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 4932a Devonshire
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St.Louis,
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4932a Devonshire
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: NICK Middle: JOHN Last: VERZINO

4. DATE OF DEATH: Month Nov. Day 19 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 7-16-1874

9. AGE (last birthday): 86

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): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: City-Retd 4 years

11. BIRTHPLACE (City and state or country): Italy (N.C.)

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Alphonse Verzino

13b. MOTHER'S MAIDEN NAME: Philomena Pizzcola

14. NAME OF HUSBAND OR WIFE: Late Mary Verzino

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 489-12-0986

17. INFORMANT: Mrs.Fannie DiLeonardo-4932a Devonshire

MEDICAL CERTIFICATION

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 Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c): 332x
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 10/2/58, to 11/19/60 and last saw ~~her~~ him alive on 11/12/60

Death occurred at 4:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert Potashnick M.D. (Degree or title)

22b. ADDRESS: 3720 Washington

22c. DATE SIGNED: 11/21/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Nov. 22,1960

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county): St.Louis, (State) Mo.

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S.Kingshighway Blvd.

25. DATE RECD. BY LOCAL REG.: NOV 21 1960

26. REGISTRAR'S SIGNATURE: Hart Smith, M.D.

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed R. W. Stoversand

Signature of Student Embalmer

Licensed Embalmer No. 400

P. O. Address St. Lo

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