

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 46-yrs.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5036 Delmar Blvd.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5036 Delmar Blvd.
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Anthony Forni			4. DATE OF DEATH Month Day Year December 27th., 1960		
5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1884	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waiter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Switzerland	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Daniel Forni		13b. MOTHER'S MAIDEN NAME Lucia Beffa		14. NAME OF HUSBAND OR WIFE Mrs. Mary Forni	
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.	17. INFORMANT Address Mr. Patrick Forni, 5036 Delmar Blvd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Art. sclerotic hypertensive heart dis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>field in ball</i>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Sout.</i>		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	
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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.) 4200
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 12-27-60 to 12-27-60 and last saw ^{her}him live on Dec 13, 1960
 Death occurred at 7:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Wayne O. Soroka M.D.</i>	(Degree or title)	22b. ADDRESS <i>100 No Euclid</i>	22c. DATE SIGNED <i>12-27-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12/30/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
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24. FUNERAL DIRECTOR <i>Arthur J. Donnell</i>	ADDRESS <i>3840 Lindell Blvd.</i>	25. DATE RECD. BY LOCAL REG. DEC 28 1960	26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>
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DOCUMENT
MEDICAL CERTIFICATION
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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm S. Salen

Licensed Embalmer No. 4699

P. O. Address 3840

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.