MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-006764

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1099

AMENDED

FILED VS FEB 20 1961

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: St. Louis
c. CITY OR TOWN: Florissant — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 250-St. Anthony-Lane — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Middle Last — Ceasar-Frank-Musso
4. DATE OF DEATH: Month Day Year — Found-Dead-2-2-61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9-22-88
9. AGE (last birthday): 72 — 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): Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (City and state or country): Italy
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John Musso
13b. MOTHER'S MAIDEN NAME: Lucy (Not Known)
14. NAME OF HUSBAND OR WIFE: -Widowed
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.
17. INFORMANT: Mrs. Lucille Russell — Address: Florissant, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of head, self
DUE TO (b): Inflicted in home on February 2, 1961.
DUE TO (c): Suicide
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
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): 976x

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.): See above
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 2-2-61
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.): Home
20f. CITY, TOWN, OR LOCATION: St Louis Mo — COUNTY — STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 10:04 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph M. Zimmer Deputy Coron
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 2-3-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-5-61
23c. NAME OF CEMETERY OR CREMATORY: Harrison
23d. LOCATION (City, town, or county): Christopher — (State): Ill.

24. FUNERAL DIRECTOR: Russell Funeral Home — ADDRESS: Christopher Ill
25. DATE RECD. BY LOCAL REG.: FEB 3 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED: 8 | BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

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 Joseph J. Kossley

Licensed Embalmer No. 1541

P. O. Address E. St. Louis,

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.