

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9958** STATE FILE NUMBER

AMENDED FILED NOV 8 1961

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 b. 59-yrs.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		d. STREET ADDRESS (If outside, give location) 2723a Bacon Street	

3. NAME OF DECEASED (Type or print) First Fiore Middle Tesone Last			4. DATE OF DEATH Month October Day 25th Year 1961		
5. SEX M.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/4/1885	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) South America	12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Thomas Tesone	13b. MOTHER'S MAIDEN NAME Isabel DeSalvo	14. NAME OF HUSBAND OR WIFE Mary C. Tesone	

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 Mr. Thomas Tesone, 864 Gustav Ave.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Diabetes Mellitus	10 years
	DUE TO (c) 260x	

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	
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

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 Jan 1957 to Death and last saw him alive on Oct 25, 1961 Death occurred at 10:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Dr. Linton W. (Degree or title)	22b. ADDRESS 3400 N. Kingshighway	22c. DATE SIGNED 10/26/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/28/1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. OCT 27 1961	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.
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DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

SHOULD READ

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 

Licensed Embalmer No. 4699
P. O. Address 3840 Lumbell

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.