

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042165

AMENDED

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

REGISTERED NURSE

STATE

FILED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11415 STATE FILE NUMBER

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		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>ST. LOUIS CITY HOSP. #1</u>		d. STREET ADDRESS (If outside, give location) <u>4228 Westminister</u>	
Inside Limits Yes <input 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>LEVI</u> Middle <u>S.</u> Last <u>ANTILLA</u>	4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>61</u>
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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>5/18/1907</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Republic Mich</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>Issac Antilla</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Ahol</u>	14. NAME OF HUSBAND OR WIFE <u>Dollie Lacefield</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW 2</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Issac Antilla 12851 Westbrook Mich.</u>	Address <u>Detroit Mich.</u>
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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) <u>Adenocarcinoma of Stomach with metastases to liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>151X</u>		<u>Unknown</u>
DUE TO (c)		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 <u>II/8/61</u> to <u>Dec 11/5/61</u> and last saw her/him alive on <u>Dec 11/5/61</u>
Death occurred at <u>7:20 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Leo J. Mulligan M.D.</u>	22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	22c. DATE SIGNED <u>II/5/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec 8, 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks Mo</u>
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24. FUNERAL DIRECTOR <u>E.J. Schnur 3125 Lafayette</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 7 1961</u>	26. REGISTRAR'S SIGNATURE <u>Lead Smith M.D.</u>
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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 Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.