

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32329

State File No. \_\_\_\_\_  
Registrar's No. 8797

Registration District No. 318 Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town: St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Christian Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution on arrival  
(Specify whether in this community years, months or days) 52 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town: St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5836 Pamplin Ave.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Augustino Sansone

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife: Anna Sansone

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: August 20, 1886  
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Italy (City, town, or county) (State or foreign country) 5

10. Usual occupation: Fruit Dealer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name: Michael Sansone

13. Birthplace: Italy (City, town, or county) (State or foreign country) 5

14. Maiden name: Frances Passifuma

15. Birthplace: Italy (City, town, or county) (State or foreign country) 5

16. (a) Informant: J. J. Sansone

(b) Address: 5836 Pamplin Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 16, 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Bernard Nichols

(b) Address: 143 Union Bldg. St. Louis, Mo.

19. (a) (Date received local registrar) OCT 11 1945 (b) (Registrar's signature) J. F. Bredeek

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10 year 1945 hour 12 minute 40 a.m.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Sclerosis  
Atherosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: HT  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature: Patrick E. Taylor (M. D. or other) \_\_\_\_\_  
Address: Albany, Coroner Date signed: 10-11-45

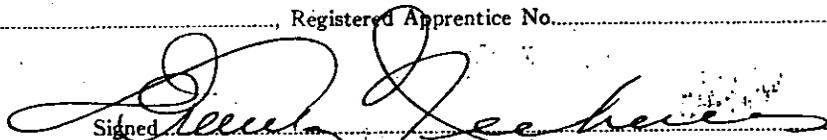
MAY 12 1954

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed



Licensed Embalmer No. 2910

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.