

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32591

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>3253</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, write RURAL and give town) <u>Affton</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>15 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Affton</u>		d. STREET ADDRESS (If rural, give location) <u>4600 Heidelberg</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4600 Heidelberg</u>				d. STREET ADDRESS <u>4600 Heidelberg</u>			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>Joe</u>	b. (Middle)	c. (Last) <u>Risalvato</u>	(Month) <u>9</u>	(Day) <u>19</u>	(Year) <u>49</u>	male <u>U</u>	6. COLOR OR RACE <u>white</u>
(Type or Print)							
5. SEX <u>male U</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>April 11-84</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		9. AGE (In years) (last birthday) <u>65</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Pat Risalvato</u>		13b. MOTHER'S MAIDEN NAME <u>Therisa</u>		14. NAME OF HUSBAND OR WIFE <u>Rosie Risalvato</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Rosie Risalvato</u>		ADDRESS <u>4600 Heidelberg</u>	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>				<u>1 day</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis +</u> DUE TO (c) <u>asthma chronic</u>				<u>10 years</u>	
19a. DATE OF OPERATION		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>4 1/2</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>450.0</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home; farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>49</u> , to <u>Sept 19</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Sept 18</u> , 19 <u>49</u> , and that death occurred at <u>10 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert N. T. Cleaver M.D.</u>				23b. ADDRESS <u>P.O. Box 6 Springfield 23 Mo.</u>		23c. DATE SIGNED <u>9-20-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>9-22-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Lemay 23, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-21-49</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Hamke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fendler Und. Co.</u>		ADDRESS <u>7429 Michigan Ave</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

LA-81 Dr. Luchman
4602 Gravois
Pl. 11600

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
Student Embalmer

Signed W. L. Morris

Licensed Embalmer No. 3260

P. O. Address 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 this body is not embalmed, fact should be so stated above.