

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18425**
Registrar's No. **4225**

FILED MAY 19 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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, write RURAL and give township) St. Louis Mo.	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	2079
d. FULL NAME OF HOSPITAL OR INSTITUTION 4747 Beacon Ave.		d. STREET ADDRESS (If rural, give location) 4747 Beacon Ave.	

3. NAME OF DECEASED (Type or Print) Anthony Pusateri			4. DATE OF DEATH (Month) (Day) (Year) May 2 1952		
a. (First)	b. (Middle)	c. (Last)			

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 17 1897	9. AGE (In years last birthday) 54	if UNDER 1 YEAR Months	if UNDER 1 YEAR Days	if UNDER 1 MIN. Hours	if UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Fruit		11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME Cosmo Pusateri		13b. MOTHER'S MAIDEN NAME Pearl Cira		14. NAME OF HUSBAND OR WIFE Margaret Pusateri	
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Margaret Pusateri				ADDRESS 4747 Beacon	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion							
*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)						
	DUE TO (c)						
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H201	
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22. I hereby certify that I attended the deceased from **May 1947** to **May 2, 1952**, that I last saw the deceased alive on **May 2, 1952**, and that death occurred at **9:45 AM** from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) D. D. Flanagan		23b. ADDRESS 5397 N. Grand		23c. DATE SIGNED 5/6/52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/6/52	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
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DATE REC'D BY LOCAL REG. MAY 6 1952	REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 N. Euclid Ave.		
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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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Gustav W. Dutilleul

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, Mo*

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.