

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2575
0521

FILED FEB 2 1954

State File No.

Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3933 S. Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros Hospt		248	

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) Restaso c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) January 16 1954		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Single	8. DATE OF BIRTH May 1 1864	9. AGE (In years last birthday) 89	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dent. Know	10b. KIND OF BUSINESS OR INDUSTRY Dent. Know	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Domingo Restaso	13b. MOTHER'S MAIDEN NAME Maria ?	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Alexian Bros Hospt	ADDRESS 3933 S. Broad
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying such as heart failure, asphyxia, etc. It means the disease, the complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mo + 1 1/2 yrs. 4 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Vascular-Renal failure		
	ANCECEDENT CAUSES (b) Senility		
II. OTHER SIGNIFICANT CONDITIONS (c) Fracture of hip.			

19a. DATE OF OPERATION 9/25/53	19b. MAJOR FINDINGS OF OPERATION Open reduction hip.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a. in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 442X F
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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?
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22. I hereby certify that I attended the deceased from 9/25 1863, to 1/16 1954, that I last saw the deceased alive on 1/16 1954, and that death occurred at 8 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. C. Schopp M.D.	23b. ADDRESS 505 Humboldt	23c. DATE SIGNED 1/18/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 19 1954	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. JAN 18 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Weick Bros	ADDRESS 2201 S. Grand Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Alvin Schapp
539 N Grand Blvd
Je 8640 1.30 to 4

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

Licensed Embalmer No. *4053*

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.