

Death, Warfare, Public Health Service
 300 0
 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

18570

FILED JUN 7 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4339** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Affton, Mo		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word		Length of stay in 1b 3 days	d. STREET ADDRESS 7113 North Villanova		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Louise Middle Last Dal Sasso			4. DATE OF DEATH Month May Day 6 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1887	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Kept House	11. BIRTHPLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Frederic			14. MOTHER'S MAIDEN NAME Louise Mueller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT John A. Dal Sasso Address 7113 N. Villanova		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis Arteriosclerosis DUE TO (b) arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)				INTERVAL BETWEEN ONSET AND DEATH 7 days 4 y	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION 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.) 420.1		
20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 					
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.) 5-1-57	20f. CITY, TOWN, OR LOCATION 5-5-57	COUNTY 5-5-57	STATE 5-5-57
21. I attended the deceased from 5/1-57 to 5/5-57 and last saw her alive on 5/5-57 Death occurred at A. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Frank J. Swekoski M.D.			22b. ADDRESS 8818 Gravois		22c. DATE SIGNED 5/7/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE May 7, 1957	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		23d. LOCATION (City, town, or county) (State) St. Louis, Mo
24. FUNERAL DIRECTOR Weick Bros ADDRESS 2201 S. Grand Blvd		25. DATE RECD. BY LOCAL REG. MAY 7 '57		26. REGISTRAR'S SIGNATURE Carl Smith	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

3312 Maple 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 _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed _____
Margaret Stetson
Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.