

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35259**

FILED NOV 1 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 86 PRIMARY REG. DIST. NO. 5323 Registrar's No. 27-1957

1. PLACE OF DEATH a. COUNTY <b>Crawford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Crawford</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Knobview Twp</b>		c. CITY OR TOWN <b>Rural</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>None</b>		e. STREET ADDRESS (If rural, give location) <b>Knobview twp</b> <span style="float: right;">280</span>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph</b> b. (Middle) _____ c. (Last) <b>Tessaro</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 15, 1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 31, 1906</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Angelo Tessaro</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Trettenero</b>	14. NAME OF HUSBAND OR WIFE <b>Edith</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>none</b>	16. SOCIAL SECURITY NO. <b>493-12-429</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Edith Tessaro, Rosati, Missouri</b>	ADDRESS _____
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Coronary Occlusion</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>1 1/2 yrs.</b>
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Previous Coronary Occlusion</b>		<b>Unknown</b>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? <b>2</b> 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) <b>4200</b>
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 10-1-57, 1957, to 10-15, 1957, that I last saw the deceased alive on 10-15, 1957, and that death occurred at 2:30P m., from the causes and on the date stated above.

23a. SIGNATURE <b>Samuel C. Bonney Jr. M.D.</b> (Degree or title)	23b. ADDRESS <b>Stricker Clinic St. James Mo</b>	23c. DATE SIGNED <b>10-16-57</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>OCT-18-1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>Rosati, Missouri</b>

DATE REC'D BY LOCAL REG. <b>10/18/1957</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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JUL 28 1969

**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 *C. June Gahr*.....

Licensed Embalmer No. *4486*.....

P. O. Address *St. James*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.