

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006861

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No.

Primary Registration District No.

Registration No.

1353

300  
-57

93  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. ANTHONY HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>4333 SUNSHINE DR</b>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle Last <b>ANTOON</b>			4. DATE OF DEATH Month <b>FEB</b> Day <b>5</b> Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 5 1885</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MERCHANT</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>LEBANON 0</b>	12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>
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13a. FATHER'S NAME <b>ANTHONY ANTOON</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>ROSE ANTOON</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>ROSE ANTOON 4333 SUNSHINE DR</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>following a suppurative prostaticitis + cystitis</b> DUE TO (c) <b>610X</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <b>Oct 15-58</b> to <b>Feb 5-59</b> and last saw her alive on <b>Feb 5-59</b> Death occurred at <b>6:30 PM</b> on the date stated above; and to the best of my knowledge, from the cause stated.
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22a. SIGNATURE <b>Stephen M. Tappin M.D.</b>	(Degree or title)	22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED <b>Feb 7-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB 9 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER + PAUL</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
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24. FUNERAL DIRECTOR <b>Thomas Ruto 2906 Gravois</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>FEB 9 '59</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith. M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

PM 728  
Te5-8885

Will 12 mos

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 Tom C Hill

Licensed Embalmer No. 4347  
P. O. Address 2906

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.