Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-022641

STATE FILE NUMBER 25426

FILED JUN 18 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Anthony Hosp. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4167 Shaw Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First JULIE	Middle ANN	Last ANASTASOFF	4. DATE OF DEATH Month June Day 6 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH June 5,1959	9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 0 Days 0 — IF UNDER 24 HRS Hours 11 Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George P. Anastasoff	13b. MOTHER'S MAIDEN NAME Faye M. Ewing	14. NAME OF HUSBAND OR WIFE -------		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Address George P. Anastasoff 4167 Shaw Ave.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Neonatal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 18 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____

DUE TO (c) ____ 762.0

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 ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6-5-59, to 6-6-59 and last saw her/him alive on 6-5-59.
Death occurred at 10:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert A. Brennan M.D.	22b. ADDRESS 3606 Gravois	22c. DATE SIGNED 6-6-59.

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 8,1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser — ADDRESS 4228 S.Kingshighway	25. DATE RECD. BY LOCAL REG. JUN 8 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. MDB	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Social, cultural, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Richard W. Storrsand

Licensed Embalmer No. 4007

P. O. Address .....

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