

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038049**

**FILED VS. OCT 19 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9246**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Macoupin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in lb <b>4 days</b>	c. CITY OR TOWN <b>Stanton</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Box 142</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>NMN</b> Last <b>SAOTTINI</b>			4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>6</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/22/1914</b>	9. AGE (last birthday) <b>45</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>

13a. FATHER'S NAME <b>Angelo Saottini</b>		13b. MOTHER'S MAIDEN NAME <b>Lucy Serentha</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>364-18-0801</b>		17. INFORMANT <b>Louis Saottini, Stanton, Ill.</b> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b>			<b>1 WEEK</b>
DUE TO (b) <b>MALIGNANT MELANOMA WITH WIDESPREAD METASTASES (PRIMARY SITE SKIN OF BACK, SUSPECTED)</b>			<b>3 WEEKS</b>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

21. I attended the deceased from **OCT. 2, 1959** to **OCT. 6, 1959** and last saw her/him alive on **OCT. 6, 1959**  
Death occurred at **1:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>H. Bradley</i>		(Degree or title) <b>M. D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>10/6/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-8-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Stanton, Ill.</b>	
24. FUNERAL DIRECTOR <b>Huntman-Fritz Funeral Home, Stanton, Ill.</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 8 '59</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

HEALTH OFFICE

MISSISSIPPI

DATE

TIME

1. Name

of the deceased

is

2. Sex

of the deceased

is

3. Age

of the deceased

is

4. Cause

of death

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 Robert A. Muz

Licensed Embalmer No. 6236

P. O. Address Stanton, Miss

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.