

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 50 yrs	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hos pital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) Glasgow 3720 Glasco
3. NAME OF DECEASED (Type or print) First Joseph Middle Arcobasso Last _____		4. DATE OF DEATH Month Dec Day 9 Year 1960	

5. SEX Male	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 Aug 6, 1900	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab	11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Joseph Arc obasso		13b. MOTHER'S MAIDEN NAME Modesta		14. NAME OF HUSBAND OR WIFE Gene Arcobasso		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address Glasgow Ge ne Arcobasso 3720 Glasco			

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebral Vascula Accideni**

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

DUE TO (b) **Generalized Arterio Sclerosis**

DUE TO (c) **331x**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Hypertensive Cardiovascular Disease

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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.)
Coronary Insufficiency

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 **9-16-59** to **12-1-60** and last saw him alive on **12-2-60**

Death occurred at **Five am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Robert B. Meyer M.D.

22b. ADDRESS
634 W. Grand

22c. DATE SIGNED
12-9-60

23a. BURIAL, CREMATION, REBURYAL (Specify)
Burial

23b. DATE
Dec 12, 1960

23c. NAME OF CEMETERY OR CREMATORY
Galvary Cemeter y

23d. LOCATION (City, town, or county) (State)
St. Louis Mo

24. FUNERAL DIRECTOR
Niceli 1150 N. Kingshighway

25. DATE RECD. BY LOCAL REG.
DEC 10 1960

26. REGISTRAR'S SIGNATURE
Loan Smith. M.D.

DOCUMENT

 MEDICAL CERTIFICATION

 BY AFFIDAVIT OF

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 Oliver R. Sedwell

Licensed Embalmer No. 4077
P. O. Address St Louis

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.