

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

3722

61-014891

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

FILED APR 27 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3818 Michigan Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Anthony		4. DATE OF DEATH Month April Day 16 Year 1961	
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 11/3/1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottler		10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (City and state or country) St. Louis Mo.
13a. FATHER'S NAME Fredrick Anthony		13b. MOTHER'S MAIDEN NAME Mary Hampel	
15. WAS DECEASED EVER IN U.S. FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Mrs. Katie Anthony	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) ATHEROSCLEROSIS DUE TO (c) 420.1H PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BRONCHOGENIC CARCINOMA LEFT		14. NAME OF HUSBAND OR WIFE Katie Glas Anthony Address 3818 Michigan Ave. 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 checked="" type="checkbox"/> NO <input 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 4-6-61 to 4/16/61 and last saw him alive on 4-16-61 Death occurred at 10:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) William S. Seleskie MD		22b. ADDRESS 3722 Washington	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/19/61	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR Gebken Sons		25. DATE RECD. BY LOCAL REG. APR 18 1961	
ADDRESS 2630 Gravois Ave		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Richard J. Gaudin*

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22, Mo.

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.