

FILED AUG 21 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26756

3282

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (In this place) 5 weeks		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City 3138		d. STREET ADDRESS (If rural, give location) 577 Forest	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hosp.							
3. NAME OF DECEASED (Type or Print) ROSE		a. (First)		b. (Middle)		c. (Last) BERBIGHIA	
4. DATE OF DEATH (Month) (Day) (Year) 7-30-50		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH 5-16-1892		9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days 2 14		IF UNDER 24 HRS. Hours Min. 0 0	
10a. USUAL OCCUPATION (Give kind of work done at least most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salerno Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Dete Mandazzo		13b. MOTHER'S MAIDEN NAME Antonida Gusmano		14. NAME OF HUSBAND OR WIFE Joseph Berbiglia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or name of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Joseph Berbiglia 577 Forest			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden coronary thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary disease DUE TO (c) Diabetes mellitus arterial hypertension				INTERVAL BETWEEN ONSET AND DEATH Unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 19 50 to 7-30 19 50 that I last saw the deceased alive on 7-22-19 50 and that death occurred at 9 A. M., from the causes and on the date stated above.							
23a. SIGNATURE Anthony S. Saladino (Degree or title)				23b. ADDRESS 1240 Olive St. St. Louis		23c. DATE SIGNED 8-1-1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/2/50		24c. NAME OF CEMETERY OR CREMATORY St. Mary's		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. 8-1-50		REGISTRAR'S SIGNATURE Geraldine Palmer		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *John B. [Signature]*

Licensed Embalmer No. 4773

P. O. Address Gaines Co. 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 this body is not embalmed, fact should be so stated above.