

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5265
Registrar's No. 5265

BIRTH NO. 40298-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>2160</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Louis</u>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Anthony Hospital</u>		e. CITY (If outside corporate limits, write RURAL and give township) <u>St Louis MO</u>	
f. STREET ADDRESS (If rural, give location) <u>3252 Morganford</u>			
3. NAME OF DECEASED a. (First) <u>Joseph</u> b. (Middle) <u>Moro</u> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>June 6 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>June 6 1951</u>
9. AGE (In years last birthday) <u>7</u>	10. MONTHS <u>7</u>	11. HOURS <u>7</u>	12. MIN. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MO</u>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <u>Joseph Moro</u>	13b. MOTHER'S MAIDEN NAME <u>Grace</u>	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Joseph Moro</u> ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congenital Hydrocephalus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Congenital deformity of arms & legs</u>	
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>752X</u>	
22. I hereby certify that I attended the deceased from <u>6/6</u> 19 <u>51</u> to <u>6/6</u> 19 <u>51</u> , that I last saw the deceased alive on <u>6/6</u> 19 <u>51</u> , and that death occurred at <u>4:10 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Hubert P. Smith, MD</u> (Degree or title)		23b. ADDRESS <u>5203 Chaffern Dr.</u>	23c. DATE SIGNED <u>6/7/51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>June 8 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	24d. LOCATION (City, town, or county) (State) <u>St Louis MO</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>J. B. Luster</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Calabroterra</u>		ADDRESS

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
Student Embalmer

Signed

Ray O. Calcaterra

Licensed Embalmer No. 2376

P. O. Address.....

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.