

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25 P. 5  
230  
729  
State File No. 28253  
7796

BIRTH NO. \_\_\_\_\_ REG. DIST. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY 0  
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  
c. LENGTH OF STAY (In this place) 6 Wks.  
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Benton b. COUNTY Franklin  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Benton 8120  
d. STREET ADDRESS (If rural, give location) 705 BEATRICE ST. 8

3. NAME OF DECEASED  
a. (First) Harry b. (Middle) EDWARD c. (Last) Saravaglia  
4. DATE OF DEATH (Month) (Day) (Year) Aug. 31 1951

5. SEX male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)  MARRIED  
8. DATE OF BIRTH Aug. 28 1951 9. AGE (In years last birthday) 23 10. MONTHS 3 11. DAYS 1 12. HOURS 11 13. MIN. 1

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) ILL. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Harry Saravaglia 13b. MOTHER'S MAIDEN NAME MARJORIE MOBENSKI 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 Freeman General Arms ADDRESS Benton Ill.

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Congestive heart failure  
\*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  
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. Spina bifida  
INTERVAL BETWEEN ONSET AND DEATH Life

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? 7544

22. I hereby certify that I attended the deceased from Aug 30, 1951, to Aug 31, 1951, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jno P Coletto M.D. 23b. ADDRESS 4952 Maryland 23c. DATE SIGNED Sept 15 1951

24a. BURIAL, CREMATION, REMOVAL (Specify) 24b. DATE SEPT 3, 1951 24c. NAME OF CEMETERY OR CREMATORY Mt. O.O.F Cemetery 24d. LOCATION (City, town, or county) (State) Benton Ill

DATE REC'D BY LOCAL SEP 4 1951 REG. REGISTRAR'S SIGNATURE J. Earl Smith M.D. W.F.F. FUNERAL DIRECTOR'S SIGNATURE Ruel-Campbell Mortuary ADDRESS 4215 Lindbergh

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

*Rev. E. Campbell*

Signed.....

Student Embalmer

Licensed Embalmer No. *3881*

P. O. Address *St. Louis, 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.**