

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38707

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10932**

1. PLACE OF DEATH

a. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis, Mo

c. LENGTH OF STAY (In this place) _____

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FAITH HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE MISSOURI

b. COUNTY _____

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,

d. STREET ADDRESS (If rural, give location) 4708 GENEVIEVE AVE

3. NAME OF DECEASED

a. (First) SAMUEL

b. (Middle) C.

c. (Last) BERLOTTI SR.

4. DATE OF DEATH (Month) (Day) (Year) DEC, 8, 1951

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH MAY 15, 1890

9. AGE (In years last birthday) 61

If under 1 year: Months _____ Days _____

If under 1 min. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) ITALY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME UNKNOWN

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE JULIA BERLOTTI

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'S SIGNATURE OR NAME JULIA BERLOTTI

ADDRESS 4708 GENEVIEVE AVE

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

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH 1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? H201

22. I hereby certify that I attended the deceased from June, 1947, to 12-8, 1951, that I last saw the deceased alive on 12-8, 1951, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph B. Guccione M.D.

23b. ADDRESS 2801 N. Taylor

23c. DATE SIGNED 12-10-51

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 12/11/51

24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY

24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI

25. FUNERAL DIRECTOR'S SIGNATURE J. Paul Smith M.D.

ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE

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

DATE REC'D BY LOCAL REG. DEC 10 1951

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

Albert Mayfield

Licensed Embalmer No. *3077*

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.