

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21901**

FILED JUL 15 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6036**

1. PLACE OF DEATH a. COUNTRY		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Illinois b. COUNTY Bend	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bend	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 403 W Central	
3. NAME OF DECEASED (Type or Print) JOSEPH		4. DATE OF DEATH (Month) (Day) (Year) DEAMBROGIO 6 25 52	
5. SEX male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 9-23-1908	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 7		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (City and State or Foreign Country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Louis Deambrogio		13b. MOTHER'S MAIDEN NAME Josephine Marno Dell	
14. NAME OF HUSBAND OR WIFE Dell Deambrogio		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Dell Deambrogio		ADDRESS Bend Ill	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYELOSCLEROSIS 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. ANEMIA; OLIGURIA	
19a. DATE OF OPERATION 6/25/52		19b. MAJOR FINDINGS OF OPERATION SPLENECTOMY	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 2923		22. I hereby certify that I attended the deceased from 5/30 , 19 52 , to 6/25 , 19 52 that I last saw the deceased alive on 6/25 , 19 52 , and that death occurred at 9:20 pm. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) G. B. Rader, M. D.		23b. ADDRESS 600 S. KINGSHIGHWAY	
23c. DATE SIGNED 6/25/52		24. BURIAL (CREMATION) REMOVAL (Specify) 6-25-52 Valhalla Crematory Bend St Louis Co Mo	
24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service 4104 Manchester Ave	
DATE REC'D BY LOCAL REG. JUN 27 1952		REGISTRAR'S SIGNATURE Carl Smith MD mds (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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ben Hoffman

Licensed Embalmer No. 4366

P. O. Address St Louis 570

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.