

STANDARD CERTIFICATE OF DEATH

State File No.

1409

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (In this place) 1 Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St Louis		2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital				d. STREET ADDRESS (If rural, give location) 3260 Regal Pl			
3. NAME OF DECEASED (Type or Print) a. (First) Julius		b. (Middle) C		c. (Last) Repetto		4. DATE OF DEATH (Month) (Day) (Year) Feb 5, 1953	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Sept. 17, 1869	
9. AGE (In years last birthday) 83		10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) City Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Vincent Repetto		13b. MOTHER'S MAIDEN NAME Angeline Botto		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) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph C Repetto 4567 Loughborough			
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) Cardiac failure				INTERVAL BETWEEN ONSET AND DEATH	
* This does not mean the mode of dying, such as heart failure, asphyxia, 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) Arteriosclerotic Ht. disease DUE TO (c) Generalized AS.					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign Prostatic Hypertrophy					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200			
22. I hereby certify that I attended the deceased from Jan 18, 1953 to Feb 5, 1953 , that I last saw the deceased alive on Feb 5, 1953 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John Goldsby M.D.				23b. ADDRESS Jewish Hospital St. Louis		23c. DATE SIGNED 2/5/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/7/53		24c. NAME OF CEMETERY OR CREMATORY N St Marcus Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D BY LOCAL REG. FEB 6 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons		ADDRESS 7027 Gravois	

(Licensed Embalmer's Statement on Reverse Side)

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

FILED FEB 26 1953

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.....

E. P. Kedwell

Signed.....
Student Embalmer

Licensed Embalmer No. 3877

P. O. Address 7027 Graves

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.