

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33193

State File No.

Registrar's No. **7889**

FILED SEP 24 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		d. STREET ADDRESS (If rural, give location) 5240 Wilson Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) c. (Last) DILIBERTO		4. DATE OF DEATH (Month) 8 (Day) 12 (Year) 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 26, 1880
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker	11. BIRTHPLACE (City and State or Foreign Country) Italy
10a. KIND OF BUSINESS OR INDUSTRY Furs		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Michael Diliberto		13b. MOTHER'S MAIDEN NAME Maria DiRimondo	
14. NAME OF HUSBAND OR WIFE Josephine Diliberto		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. Nil		17. INFORMANT'S SIGNATURE OR NAME Josephine Diliberto, 5240 Wilson	
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) Generalized Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH years 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. Chronic Brain Syndrome		19. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) 450.0		21d. HOW DID INJURY OCCUR?	
21e. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from March 14, 1953 , to August 12, 1953 , that I last saw the deceased alive on Aug. 12, 1953 , and that death occurred at 9:05 Am. , from the causes and on the date stated above.			
23a. SIGNATURE <i>Josephine Diliberto</i>		23b. ADDRESS 5600 Arsenal St.	
23c. DATE SIGNED 8/12/53		24a. BURIAL, CREMATION, REMOVAL	
24b. DATE 8-14-53		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery St. Louis County, Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Paul C. Calcaterra, 5140 Daggett St	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 12 1953		25. FUNERAL DIRECTOR'S ADDRESS	

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

(Licensed Embalmer's Statement on Reverse Side)

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ray W. Wilkins

Licensed Embalmer No. 3575

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.