

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE OF MISSOURI
42598
11215
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE 38 Enroute City Hospital		Length of stay in lb DOA	39 STREET ADDRESS 6429 Southwest
3. NAME OF DECEASED (Type or print) First Middle Last Emma Regina Sebben		4. DATE OF DEATH Month Day Year November 20, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 60
11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Attilio Counte		13b. MOTHER'S MAIDEN NAME Louigia Carbini	14. NAME OF HUSBAND OR WIFE Joseph
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. Unknown	17. INFORMANT Address Joseph Sebben, 6429 Southwest
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema & Congestion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Cirrhosis of the Liver</i> DUE TO (c) <i>Cardiac Hypertrophy</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 581-0	
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <i>940 Pth</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Frank E. Taylor Coroner</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>11-22-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <i>11-23-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Calcaterra Funeral Home, 5140 Daggett</i>		25. DATE RECD. BY LOCAL REG. <i>NOV 22 57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>m 86</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

