Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019650
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2.5208

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO. Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST.LOUIS CITY HOSP. #1. Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5436 Bischoff Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: SAM Middle: Last: SORBELLO
4. DATE OF DEATH Month Day Year: MAY 28, 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 28,1891
9. AGE (In years last birthday): 68 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: Santo Sorbello
13b. MOTHER'S MAIDEN NAME: Maria Murabito
14. NAME OF HUSBAND OR WIFE: Marie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 497-20-3922
17. INFORMANT: Marie Sorbello, 5436 Bischoff Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Basilar artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c): 332X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Aspiration Pneumonia
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 4/20/59, to 5/28/59 and last saw her/him alive on 5/28/59
Death occurred at 12:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): W. Leightner M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE
22c. DATE SIGNED: 5/28/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-1-59
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Co.,Mo.
24. FUNERAL DIRECTOR ADDRESS: Calcaterra Funeral Home,5142 Daggett
25. DATE RECD. BY LOCAL REG.: JUN 1 '59
26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.
MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....
Signature of Student Embalmer

Signed Elton R H Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.