

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3122 Easton		d. STREET ADDRESS (If outside, give location) 3122 Easton	

3. NAME OF DECEASED (Type or print) First Bartolomeo Middle Leo Last Passanante			4. DATE OF DEATH Month Dec Day 24 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1882	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coffee Merchant		10b. KIND OF BUSINESS OR INDUSTRY Coffee Sales		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY Italy	
13a. FATHER'S NAME Giovanni Passanante			13b. MOTHER'S MAIDEN NAME unk		14. NAME OF HUSBAND OR WIFE Susanna		
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. 496-366-6584		17. INFORMANT John Passanante			Address 3122 Easton

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 7 hours 8 weeks —
IMMEDIATE CAUSE (a) acute Pulmonary Edema			
DUE TO (b) Ch. Cardiac Decompensation			
DUE TO (c) H.C.V.D. - A.S.H.D			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443x			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
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20c. TIME OF INJURY Hour 10:30 Month, Day, Year Nov 27 1960 a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 St. Louis, Mo	COUNTY	STATE
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21. I attended the deceased from NOV - 60 to Dec 24 - 60 and last saw him/her alive on Dec 24 - 60	
Death occurred at 10:30 - A m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) Joseph P. Passanante MD	22b. ADDRESS 3400 N. Kingshiway	22c. DATE SIGNED 12-26-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/28/1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo	(State)
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24. FUNERAL DIRECTOR Miceli 1150 N. Kingshiway	25. DATE RECD. BY LOCAL REG. DEC 27 1960	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert W. Murray

Licensed Embalmer No. 3749
P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.