

No. 2  
12-45  
17-39  
X47070

**FILED DEC 2 1946**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis Mo.

(c) Name of hospital or institution: Firmix DeSage Hospital 0

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Baby (Infant) Zumpano

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 11 19 46  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. 51 min. \_\_\_\_\_

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name William Carl Zumpano

13. Birthplace Kane Pa. (City, town, or county) (State or foreign country)

14. Maiden name Paula Ida Fischer

15. Birthplace Lincoln Mo. (City, town, or county) (State or foreign country)

16. (a) Informant William Zumpano

(b) Address 3104 Miami St

17. (a) Burial (b) Date thereof 11-20-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation old St. Peter Paul

18. (a) Signature of funeral director Wacker-Halden

(b) Address 3634 Sprague Ave

19. (a) NOV 19 1946 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 16  
(If outside city or town limits, write "RURAL")

(d) Street No. 3104 Miami St (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 19  
year 46 hour 4 minute 40 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on 11-19-46 and that death occurred on the date and hour stated above.

Immediate cause of death congenital anomalies Duration Birth

Due to \_\_\_\_\_

Due to 157 m.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Erwin T. Hulbert (M. D. or other) MD

Address Mo. Theatre Bldg. Date signed 11-19-46

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

*Embalmer*

*no*

Signed *Robert C. Wheeler*  
Licensed Embalmer No. *2978*  
P.O. Address *Maun...*

**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.**