

No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 19 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28175

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7701**

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)

In this community 2 yrs.
years, months or days

3. (a) PRINT FULL NAME ANNA SABATINO

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex FEMALE

5. Color or race W.

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 31 - 48
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 26 hrs. 0 min.
2 less than one day

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name FRANK M. SABATINO

13. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

14. Maiden name LUCILLE VARNER

15. Birthplace CARRANDALE ILL.
(City, town, or county) (State or foreign country)

16. (a) Informant LUTH. HOSP.

(b) Address 2146 PLYMOUTH

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept. 1, 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olive (Catholic) Cemetery, Lemay, Mo.

18. (a) Signature of funeral director C. HOFFMEISTER U. & L. CO.

(b) 814 S. Broadway, St. Louis, Mo.

19. (a) 1948 (Date received local registrar)

(b) J. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1430 Dolman St.
23 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country --

MEDICAL CERTIFICATION

20. DATE OF DEATH, Modified Sept 1st day, 1948 year, 2 hour, 5 minute 5 M.

21. I hereby certify that I attended the deceased from Aug 31, 1948 to Sept 1, 1948
that I last saw her alive on Aug 31, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Birth injury

Due to Prolapsed Cord

Other conditions Deoxidized
(Include pregnancy within 3 months of death)

Major findings: 1600

Of operations _____

Of autopsy _____

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) Means of injury 0

23. Signature Chas. H. Hammers (M. D. or other) 9/1/48

Address 3012 Lafayette Date signed 1

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.