

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38765

FILED DEC 15 1951

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 10637

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, write RURAL and give town OR St. Louis, Missouri)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2219	
c. LENGTH OF STAY (in this place) 14 days		21. STREET ADDRESS (If rural, give location) 2605 Olive Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			
3. NAME OF DECEASED (Type or Print) ALBERT		4. DATE OF DEATH NOV. 29, 1951	
a. (First)		b. (Middle) BROGLIATTO	
c. (Last)			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 14, 1884
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months Days	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleman		11. BIRTHPLACE (State or foreign country) Italy	
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Annette Piccolo			
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. 497-01-0738	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS Collinsville, Ill.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic coma ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Laennec's cirrhosis. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 2 wks.		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. HOW DID INJURY OCCUR? 5811			
22. I hereby certify that I attended the deceased from 11-13-51, 19, to 11-29-51, 19, that I last saw the deceased alive on 11-29-51, 19, and that death occurred at 12:25Pm., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John T. Lawton, M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 11-29-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-1-51	
24c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		24d. LOCATION (City, town, or county) (State) Collinsville, Ill.	
DATE REC'D BY LOCAL REG. NOV 30 1951		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Ernest A. Kassy, Collinsville, Ill.	
REGISTRAR'S SIGNATURE [Signature]			

(Licensed Embalmer's Statement on Reverse Side)

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

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

not Embalmed

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Herbert A. Kassy

Licensed Embalmer No. *1803*

P. O. Address *Collinsville, Ill*

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.