

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **11529**
 Registrar's No. **2153**

FILED MAR 18 1953
 BIRTH NO. **11219**

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2269		d. STREET ADDRESS (If rural, give location) 26 1514 N 17th Str. 0
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony Hospital					
3. NAME OF DECEASED (Type or Print) Samuel Ferrante			a. (First)	b. (Middle)	c. (Last) Ferrante
4. DATE OF DEATH 2-24-53	(Month)	(Day)	(Year)		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH 2-21-53	9. AGE (in years last birthday) 3	IF UNDER 1 YEAR Months 3
IF UNDER 24 HRS. Hours 3	IF UNDER 1 Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY? Yes
13a. FATHER'S NAME Sam Ferrante		13b. MOTHER'S MAIDEN NAME Dorothy Zebrowitz		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sam Ferrante 1514 N 17th Str			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart malformation of left ventricle and aortic ducts ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerotic changes DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Phylogenetic Anomalies				INTERVAL BETWEEN ONSET AND DEATH Congestive
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)		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7544				
22. I hereby certify that I attended the deceased from 2/27, 1953 , to _____, 19____, that I last saw the deceased alive on 2/27, 1953 , and that death occurred at 10:20 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE [Signature]		(Degree or title) MD	23b. ADDRESS 3209 S. 9th	23c. DATE SIGNED 2/25/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-25-53	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St Louis County		
DATE REC'D BY LOCAL REG. FEB 25 1953	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS 1841 Cedar		

WRITE PLAINLY—USING UNFAADING 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.....

..... Student Embalmer No.

working under my personal supervision.

Not embalmed.

Student
Student Embalmer

Signed.....

Licensed Embalmer *John Steger*

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.