

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

Registration District No. **791**

File No. **3117**

Village \_\_\_\_\_

Primary Registration District No. **1003**

Registered No. **721**

City **St Louis** (NO **1922 Hereford**) St. **74** Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME **Mario Oldani**

PERSONAL AND STATISTICAL PARTICULARS

**3** MEDICAL CERTIFICATE OF DEATH

SEX **Male** COLOR OR RACE **White** SINGLE MARRIED WIDOWED OR DIVORCED **Single**  
(# write the word)

DATE OF DEATH **Jan 19, 1914**  
(Month) (Day) (Year)

DATE OF BIRTH **Aug 21, 1912**  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from **1/16, 1914**, to **1/19, 1914**, that I last saw him alive on **1/19, 1914**, and that death occurred, on the date stated above, at **5<sup>30</sup>** m.

AGE **1 yrs 4 mos 28 ds.** If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work **none 107A**  
(b) General nature of industry, business, or establishment in which employed (or employer) **none 106A 111B**

**Bronchitis - Bronchopneumonia**

BIRTHPLACE (City or town, State or foreign country) **MO**

(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

NAME OF FATHER **John Oldani**

Contributory **Dehenna of lungs**  
(SECONDARY)

BIRTHPLACE OF FATHER (City or town, State or foreign country) **Italy**

(Signed) **L. A. Millikin** M. D.  
**Yrs 1914** (Address) **4930 Shaw**

MAIDEN NAME OF MOTHER **Enrichetta Spessia**

\* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) **Italy**

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? \_\_\_\_\_

(Informant) **John Oldani**  
**for marks**  
(ADDRESS) **1922 Hereford St**

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL **S S Peter Paul**

DATE OF BURIAL **Jan 20, 1914**

Filed **JAN 20 1914** **Marb Starkloff** REGISTRAR

UNDERTAKER **Edmund Schum** **Vandeventer**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRING in plain terms, so that it may be properly classified.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County \_\_\_\_\_  
Township \_\_\_\_\_ or Village \_\_\_\_\_ or City ST. LOUIS  
Registration District No. 791 File No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_ Registered No. 721  
(No. 1922 Hereford St. 24 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mario Oldani

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) (Day) (Year)		
AGE _____ yrs. mos. ds.		If LESS than 1 day, hrs. or min.
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country)		
PARENTS	NAME OF FATHER _____ (City or town, State or foreign country)	
	BIRTHPLACE OF FATHER _____ (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER _____ (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 19, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Bronchitis Acute  
Broncho-Pneumonia

Contributory Oedema of Lungs  
(SECONDARY)

(Signed) L.A. Milliken M. D.  
7/27 1914 (Address) 4930 Shaw

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted  
If not at place of death?  
Former or usual residence \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

Filed 2-27 1914 A. B. Broegge REGISTRAR

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use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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