

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

41958

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1008**  
 City **St. Louis** (No. **1423** W. **7th**) St. .... Registered No. **11079**  
 .... St. .... Ward)

**2. FULL NAME**

**Posie Licavoli**  
 (a) Residence. No. **1423 W. 7th** St., .... X .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Infant**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 16 - 1913**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
**5 3 22**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Infant**  
 (b) General nature of industry, business, or establishment in which employed (or employer) " "  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo**  
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Jol Licavoli**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Italy**  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Josie Alivanni**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Italy**  
 (STATE OR COUNTRY)

14. INFORMANT **Josie Licavoli**  
 (Address) **1423 W. 7th St**

15. FILED **Mar 6, 1918**  
**Markoff**  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 8 1918**

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 3rd**, 1918, to **Nov. 8th**, 1918, that I last saw her alive on **Nov. 7th**, 1918, and that death occurred, on the date stated above, at **5:25** a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Lobar Pneumonia**  
 (duration) yrs. mos. ds. **10 5**  
 CONTRIBUTORY **Influenza**  
 (SECONDARY) (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

3 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Frank J. Schwarz**, M. D.

**11-5-18** (Address) **52 Potomac av.**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

**Calvary Cemetery** **Nov. 9 1918**

20. UNDERTAKER ADDRESS

**John C. Bensinger** **1138 N. 6**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

