

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

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 5408
 Township..... Primary Registration District No. 1008 Registered No. 1550
 City..... (No. 1212 1/2 9th St) St. Ward)

2. FULL NAME

Francis Buzalaki
 (a) Residence. No. 1212 1/2 9th St., 7 Ward. (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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Buzalaki
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. abt 46
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer) Housewife
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Italy

PARENTS

10. NAME OF FATHER Salvatore Gatzungaro
 11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Italy
 12. MAIDEN NAME OF MOTHER Eda Dattalo
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Italy

14. INFORMANT Frank Buzalaki (Address) 1212 1/2 9th St

15. FILED 17 19 Mar 6 Starcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 16 1921

17. I HEREBY CERTIFY That I attended deceased from 7 A.M. 15, 1921, to 7 A.M. 16, 1921 that I last saw h. in alive on Feb 16, 1921, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction
7 1/2 hrs
10015 10116 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Ovarian Cyst (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

(DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) Louis H. Mutenmacher M. D.

, 19 (Address) 2330 N. Union Blvd

*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 Calvary Cemetery DATE OF BURIAL Feb 18 1921

20. UNDERTAKER Joseph C. Bensch ADDRESS 1128 76th

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*, *Composer*, *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, peritoneum*, 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. 1550
City..... (No.) St. Ward)

2. FULL NAME Maria Busalacchi
(a) Residence. No. St. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)		
5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hra. ofmin.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)			
14.	INFORMANT (Address) <u>Joseph B. Catanzaro</u> <u>315 Commercial Bldg.</u>			
15.	FILED - 8 <u>Mar C Starckoff</u> REGISTRAR			

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR)	<u>Jan 16 31</u>
17.	I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at
THE CAUSE OF DEATH WAS AS FOLLOWS:	
..... (duration) yrs. mos. ds.	
CONTRIBUTORY (SECONDARY)	
..... (duration) yrs. mos. ds.	
18. WHERE WAS DISEASE CONTRACTED	
IF NOT AT PLACE OF DEATH?	
Did an OPERATION PRECEDE DEATH? DATE OF	
WAS THERE AN AUTOPSY?	
WHAT TEST CONFIRMED DIAGNOSIS?	
(Signed), M. D. , 19 (Address)	
*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.	
19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

5408