

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

Do not use this space.

5594

**1. PLACE OF DEATH**

County St. Louis Registration District No. 790  
 Township Richmond Heights Registration District No. 6033  
 City St. Marys Hospital (No. 1) St. Ward

File No. \_\_\_\_\_  
 Registered No. 52  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 2984 Madison 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) \_\_\_\_\_ Amorina Calabrese

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 15, 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
34 10 29

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Shoe Worker  
 (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) Italy

10. NAME OF FATHER Flaviano Calabrese

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

12. MAIDEN NAME OF MOTHER Rose D. Leo

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

14. INFORMANT (Address) A.M. Calabrese  
4212 Castleman Ave

15. FILED 2/17/25 J. B. Midditt REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1925

17. I HEREBY CERTIFY, That I attended deceased from July 1922, 1922 to Feb 14, 1925 that I last saw him alive on Feb 15, 1925, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

1. Hodgkins Disease  
2. Pseudo Leukemia  
 CONTRIBUTORY (SECONDARY) 65  
 18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH?  
 DID AN OPERATION PRECEDE DEATH? no DATE OF none  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? biopsy  
 (Signed) Chromwell M. D.  
 (Address) 313 University Club

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Calvary Cemetery 2/17/1925  
 20. UNDERTAKER ADDRESS  
Berguscl. 3661 Washington Bl

PARENTS

# 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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of———(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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.

STATE OF MISSOURI     }  
CITY OF ST. LOUIS     } S.S.

On this fourteenth day of January, 1927  
before me personally appeared A.M. Calabrese, who being duly  
sworn, on oath, declares;

That he resides at 4213 Castleman Avenue,  
St. Louis, Missouri, and that he was a brother of FIORE MARINO  
CALABRESE, who died in St. Louis, Missouri, February 15, 1925. That said  
brother was born in Italy on March 15, 1891 and not March 15, 1890  
as previously certified. That said deceased left surviving him  
a widow, Amorina Calabrese, nee Gallo, and two children, Joseph  
and Rose Calabrese.

That the name of said deceased brother was  
certified to the Bureau of Vital Statics of the Missouri State  
Board of Health as FIORE CALABRESE, whereas the correct name  
is FIORE MARINO CALABRESE.

That the said Fiore Calabrese and Fiore Marino  
Calabrese were the same and identical person who died on February  
15th, 1925, as above stated.

That this affidavit is made for the purpose of  
informing the State Board of Health as to the correct name of the  
said Fiore Calabrese, so that the said Board may enter the proper  
correction, FIORE MARINO CALABRESE, and note the year of his birth as  
1891 and not 1890, and issue its Certificate of Death accordingly.

Further deponent sayet not.

A. M. Calabrese

Subscribed and sworn to before me the day first above written.

My commission expires August ninth, 1928

Julius J. Lebray

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

FOR 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.....  
City..... (No.....) St..... Ward.....

**2. FULL NAME** *Giore Marino Calabrese*

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX ..... 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) .....

16. DATE OF DEATH (MONTH, DAY AND YEAR) ..... 19.....

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw him *alive* on ..... 19..... and that death occurred, on the date stated above, at.....

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 15<sup>th</sup> 1891*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

*33 01*

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.  
, 19 (Address)

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration)..... yrs. .... mos. .... ds.

(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) .....

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) .....

15. FILED..... 19..... REGISTRAR

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

20. UNDERTAKER ..... ADDRESS

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