

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

Do not use this space.

25422

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City, St. Louis Mo

(No. St. Johns Hospital)

File No.....

Registered No. 7853

St. Ward)

2. FULL NAME

John Dilluvio
1211 N 10th Str

(a) Residence. No. St., 5 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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known 1875

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

Abt. 50

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) City of St Louis

(c) Name of employer

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

10. NAME OF FATHER Vito Dilluvio

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

12. MAIDEN NAME OF MOTHER Anna Barbera

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

14. INFORMANT Vito Dilluvio
(Address) 1211 N. 10th St

15. AUG 17 1925
FILED 19 Man. C. Starckoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, That I attended deceased from 8-14, 1925, to 8-15, 1925, that I last saw her alive on 8-15, 1925, and that death occurred, on the date stated above, at 10:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
Apoplexy

CONTRIBUTORY Acute Pneumonia
(SECONDARY)
Broncho (duration) yrs. mos. 1 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) W. H. Schuchter M. D.

8/17/25 - 19 (Address) 304 Humboldt St

*State the DISEASE CAUSING DEATH, or in deaths from Violence, 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

Palmyra DATE OF BURIAL Aug 18 1925

20. UNDERTAKER

John C. Berman ADDRESS 1130 N. 10th St

N. B.—Every item of information should be carefully classified. 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.

