

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

Do not use this space.

6486

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City, **St. Louis Mo.** (No. **1016 S. 18<sup>th</sup> St.**)

File No. ....

Registered No. **1697**

St. .... Ward)

**2. FULL NAME**

**Helen Spero (Spero)**

(a) Residence. No. **1016 S. 18<sup>th</sup> St.**, St. **22** Ward.

(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

4. COLOR OR RACE

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

*female white*

*infant*

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

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

*Feb 9-1927*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ..... hrs. or ..... min.

*— — 9*

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)

(STATE OR COUNTRY)

*Missouri*

10. NAME OF FATHER

*Louis Pero*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Greece*

12. MAIDEN NAME OF MOTHER

*Antonetta Michel*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Greece*

14.

INFORMANT (Address)

*Mr. L. J. Pero  
1016 S. 18<sup>th</sup> St.*

15.

FILED

*18, 1927  
Mau C Starscoff  
REGISTERED*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 18* 19 *27*

I HEREBY CERTIFY, That I attended deceased from *Feb 8* 19 *27* to *Feb 18* 19 *27* that I last saw her alive on *Feb 3<sup>rd</sup> a* 19 *27*, and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*menstruosity  
congenital deformity  
throat & no. 1  
1576* (duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY)

*15901* (duration) ..... yrs. .... mos. .... da.

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) *Walter F. Kouri*, M. D.

*Feb 18, 1927* (Address) *Two Theatre St*

\*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

*St. Matthews Cemetery Feb 18 1927*

20. UNDERTAKER

ADDRESS

*E. J. Schmur 3125 Lafayette*

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.

