

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

Do not use this space.

28987

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St Louis* (No.....)

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **8570** St. .... Ward)

**2. FULL NAME**

*Peter Muscuzzini*

(a) Residence, No. *5328 Shaw av.* St. *13* 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) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 7-1907*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<i>20</i>	<i>6</i>	<i>18</i>	

**8. OCCUPATION OF DECEASED**

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

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

PARENTS

10. NAME OF FATHER *Paul Muscuzzini*

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

12. MAIDEN NAME OF MOTHER *Pauline Liaim*

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

14. INFORMANT *Paul Muscuzzini* (Address) *5328 Shaw av*

15. FILED *SEP 26 1927* *Maub Starckoff* Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9/25* 19*27*

17. I HEREBY CERTIFY, That I attended deceased from *8/1* 19*26*, to *9/25* 19*27* that I last saw him alive on *9/24* 19*27*, and that death occurred, on the date stated above, at *10 0* m.

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

*LPH* (duration) *2* yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) *SI* (duration) ..... yrs. .... mos. .... da.

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

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? *Ray microscope*  
(Signed) *L. C. Mullikin*, M. D.  
*9/26*, 19*27* (Address) *4928 Shaw*

\*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 *St Peter - Paul* DATE OF BURIAL *Sept 28 1927*

20. UNDERTAKER *Paul G Calcaterra* ADDRESS *1921 Cooper St*

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.

