

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

Do not use this space.

38488

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

(No. **Jewish Hosp**)

File No. **11164**

Registered No. **11164**

St. Ward)

2. FULL NAME *Pete Hoggio*

(a) Residence, No. **4989 Central** St. **13** 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 *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) *aprx 19-1926*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>7</i>	<i>7</i>	<i>7</i>	<i>24</i>	

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) *St Louis*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Frank Hoggio*

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

12. MAIDEN NAME OF MOTHER *Mina Bellora*

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

14. INFORMANT *Frank Hoggio*
(Address) *4989 Central*

15. FILED *1-4-1927* 19 *Max C Starr* Registrar

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Fe. 13 27* 19

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19....., that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock + Burns
fully in both leg
at residence
CONTRIBUTORY (SECONDARY) *accident*

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) *R. Pitt* M. D.
14/11/27 (Address) *Central*

*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 *Nov 15 1927*

20. UNDERTAKER *Paul C. Calcatera* ADDRESS *1921 Cooper*

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.

