

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

Do not use this space.

38920

1. PLACE OF DEATH

County..... Registration District No. 791 File No.
 Township H. Linn Primary Registration District No. 1003 Registered No. 11661
 City St. Louis (No. 2321 Mullamphy) St. Ward)

2. FULL NAME John E. Caccialando
 (a) Residence. No. 2321 Mullamphy St. 20 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** single
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 30 - 1920

7. AGE YEARS MONTHS DATE **IF LESS than 1 day, hrs. or min.**
7 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer Haward School

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

10. NAME OF FATHER Cate Caccialando

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

12. MAIDEN NAME OF MOTHER Mary Greco

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

14. INFORMANT Mary Fazio
 (Address) 2321 Mullamphy

15. FILED DEC 28 1927 Marb Starkoff
 19..... REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 19 27

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... 11:50 A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Gun Shot Wound Chest
18 1/2 184
 (duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY) None
 (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?
 (Signed) Wm. H. Haver, M.D.

12/27, 1927 (Address) Des Moines Iowa

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary **DATE OF BURIAL** Dec 28 19 27

20. UNDERTAKER Bensiek-Mehaus **ADDRESS** 113876

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.

