

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

Do not use this space.

3178

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Dept**)

File No. **E 797**

Registered No. **E 797**

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. **307 E. Concord** Ward. _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. **3** mos. _____

How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3. SEX **Female**

4. COLOR OR RACE **White**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jun 27 1928**

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

17. I HEREBY CERTIFY That I attended deceased from **Jun 22** 19**28** to **Jun 27** 19**28** that I last saw h. **9** alive on **Jun 27** 19**28**, and that death occurred, on the date stated above, at **4** p.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 16 1901**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
26 | **5** | **5**

Chronic Myocarditis
66B
93C

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Insurance**

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

(c) Name of employer

CONTRIBUTORY (SECONDARY) **Toxic adenoma of Thyroid** (duration) yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Messina**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER **John Gulpo**

(STATE OR COUNTRY) **Italy**

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

WAS THERE AN AUTOPSY.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Italy**

WHAT TEST CONFIRMED DIAGNOSIS.....

12. MAIDEN NAME OF MOTHER **Stella Dilligini**

(STATE OR COUNTRY) **Italy**

(Signed) **Robert H. Simpson**, M. D.
1/27, 19**28** (Address) **City Dept**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Italy**

*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.

14. INFORMANT

(Address) **City Dept**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St. James Mw**

DATE OF BURIAL **7/23 1928**

15. FILED **JUN 27 1928**

Marle Starkeoff REGISTRAR

20. UNDERTAKER **Hoppsmester & Co**

ADDRESS **7874 S Broadway**

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.

THIS IS A PERMANENT RECORD

Marke