

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

Do not use this space.

6348

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. **791**  
Primary Registration District No. **1003**  
No. **2719** *Locust St.*

File No.....  
Registered No. **1217**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. **21** Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**

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

*John Solaris*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 17, 1853**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**74 6 14**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **at Home**  
(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) **Italy**

10. NAME OF FATHER **Joseph Luanta**

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

12. MAIDEN NAME OF MOTHER **Catherine Ganone**

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

14. INFORMANT **John Solaris**  
(Address) **2719 Locust St**

15. FILED **15-2 1098** **May 6 Starkeoff**  
19... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 1 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 30**, 1928, to **Feb. 1**, 1928 that I last saw her alive on **Jan. 31**, 1928, and that death occurred, on the date stated above, at **2 40 a m.**

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

**Lobar Pneumonia,**  
**10/8 10/10**

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? **NO** DATE OF.....

20. WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS? **Physical examination**  
(Signed) **M. D. Jamieson**, M. D.

**Feb. 1, 1928** (Address) **1101 Washington Blvd.**

\*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 **Calvary** DATE OF BURIAL **2-4 1928**

20. UNDERTAKER **Arthur J. Donnelly** ADDRESS **2039 Wash St**

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.

4101 Washington

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