

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

Do not use this space.

14896

1. PLACE OF DEATH

County St. Louis
Towship _____
City St. Louis (No. 500)

Registration District No. 791
Primary Registration District No. 1003

File No. _____
Registered No. 13801
St. _____ Ward _____

2. FULL NAME Francis Traia

(a) Residence No. Childrens Aid Society St. 12 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) infant

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

Infant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-21-29

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>3</u>		<u>19</u>	

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 Mo.
(STATE OR COUNTRY) U.S.A.

10. NAME OF FATHER Frank Traia

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

12. MAIDEN NAME OF MOTHER Frances Giordano

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

14. INFORMANT L. McLeod Hill
(Address) 500 So. Kingshighway

15. FILED PP-6 1029 1929 Mar C. Starkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 4 1928

17. I HEREBY CERTIFY, That I attended deceased from 4-3 1928, to 4-4 1928
that I last saw h.e.r. alive on 4-4 1928, and that death occurred, on the date stated above, at 9:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107-1
99R-1A
Branch pneumonia primary
(duration) yrs. mos. 7 ds.
CONTRIBUTORY Prematurity - 3 1/2 months
(SECONDARY)
Otitis media acute bilateral - 3 ds.
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, Home

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Russell G. Powell

4/5 1928 (Address) St. L. Childrens Hosp.

*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 Apr. 6 1928

20. UNDERTAKER Paul L. Calcaterra ADDRESS 1921 Cooper St

WRITE PENNELLY, 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.

