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.

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 28963

Township..... Primary Registration District No. 1003 Registered No. 8468

City..... (No. 1423 Cass St. ..... Ward)

2. FULL NAME Sam Signorelli

(a) Residence. No. 1423 Cass St., 26 Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR ~~DIVORCED (write the word)~~: Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary Signorelli

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 19, 1895

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
33	5	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): self
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Italy

PARENTS

10. NAME OF FATHER: Joe Signorelli
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Italy
12. MAIDEN NAME OF MOTHER: Mary Vicomonda
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Italy

14. INFORMANT: Mary Signorella
(Address) 1423 Cass

15. FILED ..... 19 ..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 19 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1928, to Aug. 19, 1928 that I last saw him alive on Aug. 19, 1928, and that death occurred, on the date stated above, at 6 15 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

101A (duration) ..... yrs. ..... mos. 12 ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Jos. P. Berman, M. D

Aug. 19, 1928 (Address) 1504 - No. 16 St

*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: Aug. 21 1928

20. UNDERTAKER: Benseck-Niehaus
ADDRESS: 1138 No 6