

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

Do not use this space.

32346

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *791*)

Registration District No. *1003*
Primary Registration District No. *St. Johns Hosp.*

File No.....
Registered No. *9658*
St. Ward)

2. FULL NAME

Sara Vitale

(a) Residence. No. *1407 Fairfield* St., *21* 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. 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 (Form the record) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 23, 1917*

7. AGE YEARS MONTHS DAYS *1 2 6* If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Nichel*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Sam Vitale*

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

12. MAIDEN NAME OF MOTHER *Rose Merumo*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis Mo*
(STATE OR COUNTRY)

14. INFORMANT *Sam Vitale*
(Address) *1407 Fairfield*

15. *007-01 1323* FILED *1928* *Mar. 6* REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 29 1928*

17. I HEREBY CERTIFY That I attended deceased from *9 11 28* to *9 29 28* that I last saw h. *42* alive on *9 29 28*, and that death occurred, on the date stated above, at *6 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS: *1138*

Ac Cardas Nitidobon
Broncho pneumonia
Secondary (duration) yrs. mos. *3* ds.
CONTRIBUTORY *Acute Gastro-enteritis* (SECONDARY) (duration) yrs. mos. *8* ds.

18. WHERE WAS DISEASE CONTRACTED? *1138*
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? *George J. McKay, M.D.*
(Signed) *9/29 28* (Address) *1606 So Jefferson*

*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 *Oct 1 1928*

20. UNDERTAKER *Dennis-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.

RECORDING INSTRUMENTS IS A PERMANENT RECORD

