

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

Do not use this space.

**1. PLACE OF DEATH**

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

Registration District No. *791*  
 Primary Registration District No. *1008*  
 (No. *3625* *Flad a*)

File No. *35581*  
 Registered No. *10652*  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. *17* Ward \_\_\_\_\_  
 (Usual place of abode)

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

**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 *Lillian Geraci*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 2 - 1892*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*36 1 27*

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) *Italy*

**10. NAME OF FATHER**

*Geraci*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Italy*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Italy*

14. INFORMANT *Lillian Geraci*

(Address) *3625 Flad av*

15. FILED *30 1928* *Max G. Starkeroff* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/29 1928*

17. I, HEREBY CERTIFY, That I attended deceased from *Oct 26*, 1928, to *Oct 29*, 1928, and that I last saw him alive on *Oct 29*, 1928, and that death occurred, on the date stated above, at *7:15 a.m.*

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

*Tuberculosis Ch. Pul*

*23A 31* (duration) *2* yrs. mos. da.

CONTRIBUTOR (SECONDARY) (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH..... *No* DATE OF.....

WAS THERE AN AUTOPSY?..... *No*

WHAT TEST CONFIRMED DIAGNOSIS..... *Clinical W-*

(Signed) *J. J. Sweeney*, M. D.  
*10/30, 1928* (Address) *17 Pleasant Bldg*

\*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 *Cabary* DATE OF BURIAL *10-31 1928*

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

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.

RECORD

3720 2nd flr  
1312

1312