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

Do not use this space.

4106

1. PLACE OF DEATH

County ..... Registration District No. 182 ..... File No. 727

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

City St Louis Mo. (No. St Louis Children's Hospital St. ..... Ward)

2. FULL NAME Julio Aiello

(a) Residence. No. 1407 G'Fallon St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-19-24

7. AGE: Years 4 | Months 7 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work — 9 108
(b) General nature of industry, business, or establishment in which employed (or employer) — 86
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Dominic Aiello
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Italy
12. MAIDEN NAME OF MOTHER Mary Evola
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Italy

14. INFORMANT L. Koelling
(Address) 500 S. Kingshighway

15. FILED 15 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-14 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-14, 1929, to 1-14, 1929, that I last saw him alive on 1-14, 1929, and that death occurred, on the date stated above, at 2 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pertussis.

About — (duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (SECONDARY) Lobar pneumonia & convulsions

(duration) 0 yrs. 0 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Examination

(Signed) A. C. Edwards, M. D.
1-14, 1929 (Address) 500 S Kingshighway

*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: Jan 16 1929

20. UNDERTAKER: Bensick. Niehaus
ADDRESS: 1138 N 6

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.

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