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

Do not use this space.

12878

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1009 Registered No. 3428

City St. Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME Bartholomeo Iano

(a) Residence. No. 801 N 6 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 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	61	10	20	

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

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

PARENTS

10. NAME OF FATHER Dominick Iano

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 Hospital Information
(Address) City Hospital

15. FILED MAR 19 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1929

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1929 to March 6, 1929 that I last saw him alive on March 6, 1929 and that death occurred, on the date stated above, at 7:10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

108

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

3/7 (Signed) Edmund R. Sheridan M. D
, 1929 (Address) City Hospital

*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 Washington U. DATE OF BURIAL 3-16 1929

20. UNDERTAKER Walter Richter ADDRESS 3500 Rutger 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.

Sano.