

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

Do not use this space.

22760

**1. PLACE OF DEATH**

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

791  
Registration District No. *1008*

Primary Registration District No. ....

File No. ....  
Registered No. *6169*

**2. FULL NAME**

(a) Residence. No. *5119<sup>th</sup> Wells* St., *6* 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 (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 3, 1925*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<i>24</i>	<i>0</i>	<i>2</i>	

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

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

10. NAME OF FATHER *Angelo Ingrassia*

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

12. MAIDEN NAME OF MOTHER *Katherine Messing*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Italy*

14. INFORMANT *Rose Ingrassia*  
(Address) *5119<sup>th</sup> Wells*

15. FILED *JUN 19 1929* *Max C. Starkloff*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 5 1929*

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... *7 a* m.

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

CONTRIBUTORY (SECONDARY) *31* (duration) ..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *J. W. Kerner, M.D.*  
*6/7 1929* (Address) *Dep. Coroner*

\*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 *June 8 1929*

20. UNDERTAKER *Bensel-Nehaus* ADDRESS *1138 N. 6<sup>th</sup> St.*

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.

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