

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

Do not use this space.

28958

**1. PLACE OF DEATH**

County..... Registration District No. 1003  
Township..... Primary Registration District No. 1003  
City..... (No. 5051 Delmar Bl. (rear))

File No.....  
Registered No. 8066  
St. .... Ward)

**2. FULL NAME** John DiBlase

(a) Residence. No. 5051 Delmar Bl. St. 12 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) Single

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

None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 3, 1911

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
18 5 1

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Services Car Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

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

10. NAME OF FATHER Joe DiBlase

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

12. MAIDEN NAME OF MOTHER Mary Lodatto

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

14. INFORMANT JOE DiBlase  
(Address) 5051 Delmar

15. FILED ALG 19 May 21 1929 REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 3 19 29

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... 6:30 p.m.

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

Gunshot Wound of Chest  
bullets fired from handgun  
of Leo Dathas at 5051 Delmar

CONTRIBUTORY (SECONDARY) Homicide  
(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? Yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) [Signature] M.D.  
8/5 1929 (Address)

\*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 DATE OF BURIAL

Catholic Aug 6 19 29

20. UNDERTAKER ADDRESS

Bensiek - Nicholas 38 North

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.

10  
16

