

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

Do not use this space.

~~21247~~
21247

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No.....)

Registration District No..... **791**
Primary Registration District No..... **1003**

File No.....
Registered No..... **6112**
St. *24* Ward)

ISOLATION HOSPITAL

2. FULL NAME

Dominick Caputo
(a) Residence No. *2010 Washington* *St.* 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)

Widower

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

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

4-27-1893

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

37

1

25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Boiler maker

(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)

Wisconsin

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14. INFORMANT

(Address)

Joe Haffler
ISOLATION HOSPITAL

15. FILED

19

May & Barker

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

6-22 19*30*

17.

I HEREBY CERTIFY, That I attended deceased from

6-21, 19*30*, to *6-22*, 19*30*

that I last saw h. *alive* on *6-21*, 19*30*, and that death occurred, on the date stated above, at *6:20 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis streptococci
Simple cause unknown

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed).....

Alfred H. ..., M. D.

6-23, 1930 (Address) **ISOLATION 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

DATE OF BURIAL

St. Paul, Minnesota

6/27, 1930

20. UNDERTAKER

ADDRESS

C. Hoffmeister
484 Broadway

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.

