

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

Do not use this space.

39511

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Ray Primary Registration District No. _____
 City ICC (No. Research Hwy) St. _____ Ward _____

File No. _____
 Registered No. 51124
 St. _____ Ward _____

2. FULL NAME

Joe Merlo St. _____ Ward _____

(a) Residence No. 522 Front
 (Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Ma 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 27 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
45 - - - 19

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

9. BIRTHPLACE (CITY OR TOWN) San Duca Sicily
 (STATE OR COUNTRY) Italy

10. NAME OF FATHER Joe Merlo

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

12. MAIDEN NAME OF MOTHER Therese Capora

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

14. INFORMANT Maria Merlo
 (Address) Widow. 522 Front

15. FILED 12/18/30 m. m. Corone
 REGISTRAR Arson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 16 1930

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental fract skull -
191B
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Struck in head with iron pipe
 (duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic
 (Signed) Chancery M. Hall M. D.
 17 _____ 16, 1930 (Address) Highly Crown
 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 St. Mary's DATE OF BURIAL 12/19 1930

UNDERTAKER St. Mary's ADDRESS ICC

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.

