

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

Do not use this space.

15112

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**
(No. **1208 North 6 St.**)

File No. **15112**
Registered No. **4034**
St. **15** Ward **6**

2. FULL NAME *Pearl Salerno*

(a) Residence. No. **1208 N. 6** St. **15** 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 25-1927*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____hra. or _____min.
		<i>11</i>	<i>17</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) *nie*
(c) Name of employer

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

10. NAME OF FATHER *Anthony Salerno*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *St Louis Mo*

12. MAIDEN NAME OF MOTHER *Jennie Baldi*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *St Louis Mo*

14. INFORMANT (Address) *Anthony Salerno 1208 North 6*

15. FILED *12 1927* *May E Stankers* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 11 1928*

17. I HEREBY CERTIFY That I attended deceased from *April 10 1928* to *April 11 1928* that I last saw him alive on *April 11 1928*, and that death occurred, on the date stated above, at *5:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

108 101A
Polar Pneumonia
(duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Frank J. Stange*, M. D.

4/12 1928 (Address) *3924 S Grand Bluffs Mo*

*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 *April 14 1928*

20. UNDERTAKER *Bensiek - Mehans* ADDRESS *1138 N 6*

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. WRITE CAREFULLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

