

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

Do not use this space.

12321

1. PLACE OF DEATH

County..... Registration District No. **79II**
 Township..... Primary Registration District No. **1000**
 City **St. Louis, Mo.** No. **5600**, **Arsenal** (41) File No. **2839**
 St. **348** (Ward)

2. FULL NAME **Tommy Fossetti**

(a) Residence. No. **1823 No 6th** St., **25** Ward.
 (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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** **4. COLOR OR RACE** **white** **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** **not known**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **not known**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **not known 1873**
7. AGE **years** **months** **days** **If LESS than 1 day, hrs. or min.**
4. hours, 55. Unknown
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **not known**
 (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) **not known**

10. NAME OF FATHER **not known**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **not known**
12. MAIDEN NAME OF MOTHER **not known**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **not known**

14. INFORMANT **Max Healdrik**
 (Address) **Isolation Hospital**

15. FILED **1929** **Mar 5** **1929**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-27-1929**
17. I HEREBY CERTIFY, That I attended deceased from 2/25, 1929, to 2/27, 1929 that I last saw him alive on 2/27, 1929, and that death occurred, on the date stated above, at 3:40 pm

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis, Meningococcus
 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED **823 N. 6th St.**
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No.** DATE OF.....
WAS THERE AN AUTOPSY? **No.**
WHAT TEST CONFIRMED DIAGNOSIS? **St. Gultype**
 (Signed) **Paul H. H. H.** M. D.
2/27/1929 (Address) 5800 Arsenal St.

*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 Cemetery** **DATE OF BURIAL** **Mar 5 1929**

28. UNDERTAKER **J. H. Gebken & Co 284 2 Meramec**
ADDRESS

✓ 1000 000 000

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis (No. _____) St. _____ (Ward)

File No. 12321
Registered No. 2839

2. FULL NAME

(a) Residence. No. _____ 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.

Tony Fossatti

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER _____
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED UN 28 Max C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/27/29 3/27 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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (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? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) _____, M. D.
. 19 _____ (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 3/5/29

20. UNDERTAKER Yobtan Mercedes ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-12324