

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

Do not use this space

3295

3194
2724

1. PLACE OF DEATH

County.....

Registration District No. 791

1003

Township.....

Primary Registration District No.

City St. Louis (No. City Hospital)

File No.

Registered No. 791

St.

Ward)

2. FULL NAME

(a) Residence. No. 2317 Cooper St., 13 Ward.

Length of residence in city or town where death occurred 18 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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 13 - 1910

7. AGE

YEARS 19

MONTHS 4

DAYS 9

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

cripple

(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) Italy

PARENTS

10. NAME OF FATHER

Sam Salamoni

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Italy

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Italy

14. INFORMANT

(Address) City Hospital

15. FILED

23 1930

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 1930

17.

I HEREBY CERTIFY That I attended deceased from Jan 13 1930 to Jan 22 1930 that I last saw him alive on Jan 22 1930 and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hodgkin's Disease
72³ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

65 B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 2317 Cooper

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Histological Section of Cervical glands

(Signed) B. Margulies M.D.

123, 1930 (Address) City 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 Peter & Paul Jan 25 1930

20. UNDERTAKER

ADDRESS

Paul Calcaterra Cooper St

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.

Salamoni