

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

Do not use this space.

25725

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... St. Louis Mo. (No. City Infirmary)

File No. 17323
Registered No. 17323
St. Ward)

2. FULL NAME

Adam Raleski
(a) Residence. No. 2118 N. 13th St., 26 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (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) widower

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
<u>About 48</u>	<u>?</u>	<u>?</u>	<u>?</u>	

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

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

10. NAME OF FATHER Antonio Raleski

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Poland

12. MAIDEN NAME OF MOTHER Rose Wimmers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Poland

14. INFORMANT Ch. Witrowe
(Address) 5800 Arsenal St.

15. AUG 13 1927 Max G Starceff
FILED REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/12 1927

17. I HEREBY CERTIFY That I attended deceased from 9/25, 1925, to 8/12, 1927, that I last saw him alive on 8/12, 1927, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Hepatitis
Chronic nephritis
(duration) 1 yrs. 10 mos. 20 da.

CONTRIBUTORY (SECONDARY)

None (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. 2118th N. 13th St.

DID AN OPERATION PRECEDE DEATH? No DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Chas. T. Wynn, M. D.
(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 St. Peter DATE OF BURIAL Aug 15th 1927

20. UNDERTAKER Aug Brockland R. & Co ADDRESS 1421 N. 9th St

FADING 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.

