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

Do not use this space.

3592

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 1261

City St Louis (No. 149 E St George St. ..... Ward)

2. FULL NAME RAYMOND KOSTECKI

(a) Residence. No. 149 E St George St., 23 Ward. (If nonresident give city or town and State)
(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 (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 6-1926

7. AGE: Years 1 | Months 1 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

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) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER: Walter Kostecki
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St Louis
12. MAIDEN NAME OF MOTHER: Sophie Raworonska
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St Louis

14. INFORMANT: Raymond Kostecki
(Address): 149 E St George

15. FILED ..... 19 ..... Max C. Barklay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 31 1928

17. I HEREBY CERTIFY, That I attended deceased from 1-31, 1928, to 1-31, 1928 that I last saw h..... alive on 1-31, 1928, and that death occurred, on the date stated above, at 5 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Diphtheria of Tonsils & Larynx 10 (duration) ..... yrs. ..... mos. 1 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. E. Heiple, M. D
19 (Address) 3860 S. Broadway

*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: Mt Olive
DATE OF BURIAL: Feb. 3 1928

20. UNDERTAKER: Central
ADDRESS: 1841 Cass

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.

...IS A PERMANENT RECORD

OK
[illegible]