

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

Do not use this space.

31568

1. PLACE OF DEATH

County St. Louis
Township Central
City St. Louis

Registration District No. 789
Primary Registration District No. 692300
(No. 3936 Council Grove Ave. Ward)

File No. _____
Registered No. 21921

2. FULL NAME

Catherine Lamkiewicz

(a) Residence No. _____ St. _____ 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 19th 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	44	4	10	9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
(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) Mo

10. NAME OF FATHER

Michael Sullivan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Josephine M. Grant

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14.

INFORMANT Joseph Lamkiewicz
(Address) 3936 Council Grove Ave

15.

FILED 9/30 1928 Wells Branch, Mo. REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/29 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1928, to Sept 28 1928 that I last saw h. alive on Sept 28 1928, and that death occurred, on the date stated above, at 8:20 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

197A Empty acmia
126B of (Gall bladder)
(duration) yrs. mos. 10 da.

CONTRIBUTORY Haemolytic jaundice
(SECONDARY)
(duration) yrs. mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: at Home

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Kroigler

(Signed) Gertrude M. D.
9/29 1928 (Address) 3442 Geraldine Ave

*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

Cemetery 10-2 1928

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly 2039 Wash St

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.

CONTINUING INFORMATION IS A PERMANENT RECORD

NOV 1890

Dr. King

3442