JAN 28 1929

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

Do not use this space.

File No. 42406

Registered No. 445

1. PLACE OF DEATH

County: St Louis County

Township: JARONDELET

City: St Louis (No. Mt. Van Buren St. ..... Ward)

Registration District No. 1123

Primary Registration District No. 8248

2. FULL NAME Ralph Lysakowski

(a) Residence. No. ..... St., ... 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. 2 / ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
M	W	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 5 1900

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
28		0	25	

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

9. BIRTHPLACE (CITY OR TOWN) Lebanon, Ill.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jno J Lysakowski

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

12. MAIDEN NAME OF MOTHER Katherine Reid

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)

14. INFORMANT John Lysakowski
(Address) Lebanon, Ill

15. FILED Dec. 31, 1928 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1928

17. I HEREBY CERTIFY, That I attended deceased from 12/5/28, 19..., to 12/30/28, 19..., that I last saw h. alive on 12/30/28, 19..., and that death occurred, on the date stated above, at 8:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Terminating Pulmonary Tuberculosis
1 2 Dy

(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? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Sputum Bacilli Positive
(Signed) Leo J Huenefeld, M. D
, 19 (Address) 9101 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: Collins Hill Lebanon, Ill — DATE OF BURIAL: Jan 2 1929

20. UNDERTAKER: Thomas J Meyer — ADDRESS: Lebanon Ill

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD