

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

Do not use this space.

15889

1. PLACE OF DEATH

County St. Louis
Township Gravois
City St. Louis

Registration District No. 1123
Primary Registration District No. 6248 A
(No. 8010 Gravois Ave)

File No. _____
Registered No. 157
St. _____ Ward _____

2. FULL NAME

Laverne Palubiak

(a) Residence. No. 8010 Gravois St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

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 Female
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) July 28 - 23

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>5</u>	<u>9</u>	<u>26</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer _____

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

10. NAME OF FATHER John Palubiak Jr

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

12. MAIDEN NAME OF MOTHER Bertha Huber

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis Mo
(STATE OR COUNTRY)

14. INFORMANT John J. Palubiak
(Address) 8010 Gravois

15. FILED Apr 29 1929 L. C. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 12/25 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

181
Accidental Burns
from Fire while writing
(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? Physicist signs

(Signed) John O'Connell, M. D.

, 19____ (Address) Roomer of S. Louis family

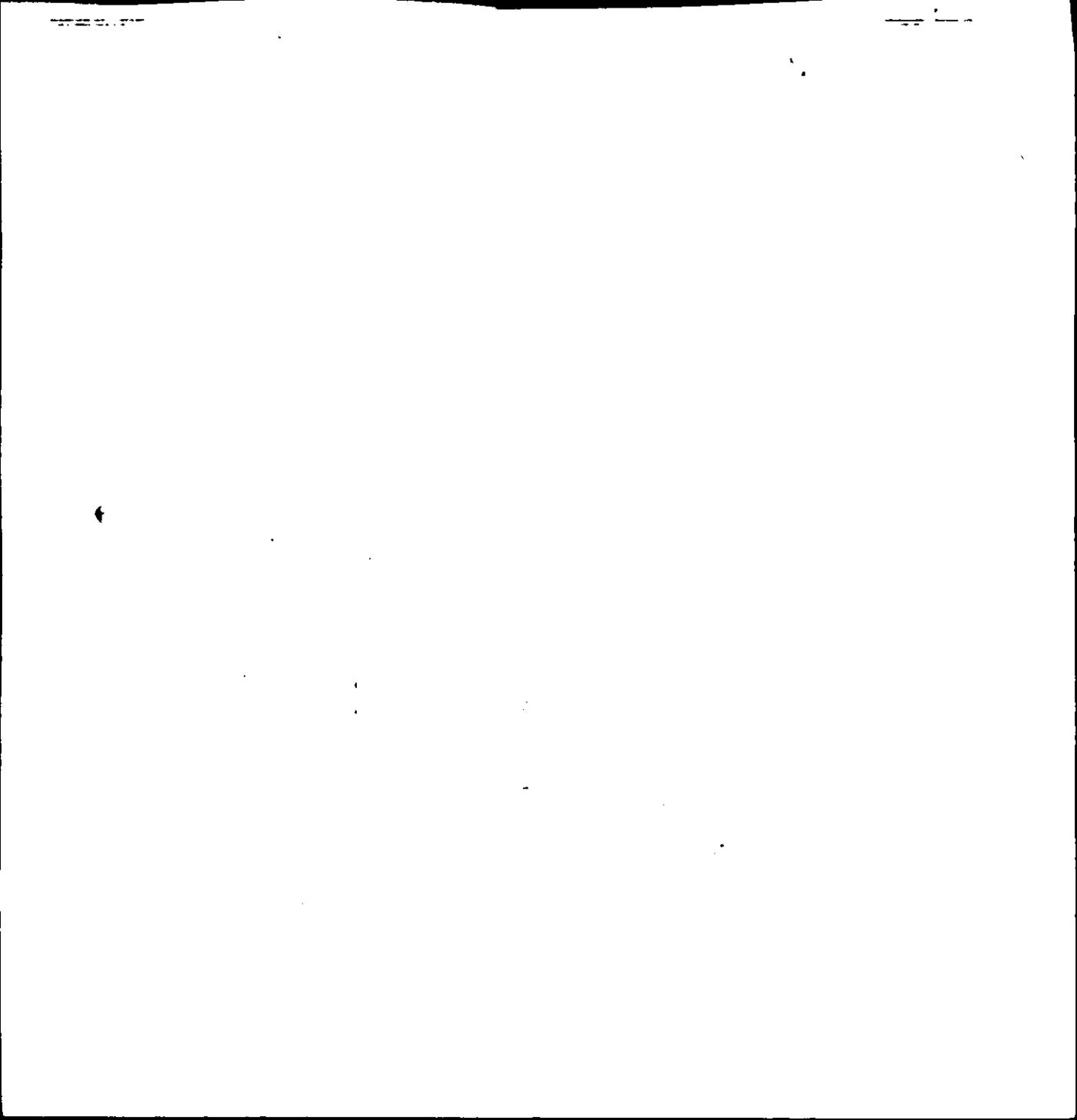
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

St. Louis Burial Park April 27 1929

20. UNDERTAKER ADDRESS

Mr. C. May dell 1926 Ave.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis
Township Worshel
City..... (No.....)..... St..... Ward.....

Registration District No. 112 3
Primary Registration District No. 6248 B

File No.....
Registered No. 157

2. FULL NAME

Lavene Palubick

(a) Residence. No..... St..... Ward.....
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

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

7. AGE YEARS MONTHS DAYS 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)

PARENTS

10. NAME OF FATHER.....
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER.....
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED 4/8, 1928 L. C. Obrodny REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1929

17. I HEREBY CERTIFY that I attended deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental Burns from fire ground Building
Burnin Building
not involved (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?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*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..... 19.....

20. UNDERTAKER..... ADDRESS.....

SUPPLEMENTARY

S-15889