

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

Do not use this space.

15919

1. PLACE OF DEATH

County St. Louis
Township Central
City University City (No. 750 Kingsland)

Registration District No. 1160
Primary Registration District No. 4470

File No. _____
Registered No. 47
St. _____ Ward _____

2. FULL NAME Louis Ladinsky

(a) Residence. No. 750 Kingsland 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 Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 15-1895

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
34	4	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Restaurant
(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) Russia

10. NAME OF FATHER Wolf Ladinsky

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

12. MAIDEN NAME OF MOTHER Fannie Sherlinsky

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

14. INFORMANT Hena Ladinsky
(Address) 750 Kingsland

15. FILED 4/23, 1929 Marie Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 22 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:

93c
Chronic Myocarditis
97 (duration) 2 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRAICTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Medical history
(Signed) John O'Connell, M. D.

4/23, 1929 (Address) Corner of 87th and 90th Sts
*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 Chesed Shel Emeth Cem. **DATE OF BURIAL** April 23 1929

20. UNDERTAKER A. Rindskopf **ADDRESS** 5216 Delmar

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.

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