

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

Do not use this space.

33994
4447

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kan Primary Registration District No. 1002
 City Kansas City Mo (No. Trinity Lutheran) (Ward)
 2. FULL NAME Laura Ladzinski
 (a) Residence No. 3422 Baltimore Ave Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 20 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albert Ladzinski
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 7 - 1884
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44 10 26
 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) Denmark
 10. NAME OF FATHER F Holm
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Denmark
 12. MAIDEN NAME OF MOTHER not known
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Denmark
 14. INFORMANT Albert Ladzinski
 (Address) 3422 Baltimore Ave
 15. FILED 10/28/29 M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/28 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 _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental
automobile collision
210 M (duration) yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 1880 (duration) yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED? 215
 IF NOT AT PLACE OF DEATH. _____
 1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 10/25/29
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS autopsy
 (Signed) Stanley M. Hall, M. D.
10/28/29 (Address) 1409 Grand 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 St. Noriah Cemetery DATE OF BURIAL Oct 29 1929
 20. UNDERTAKER John W. Wagner ADDRESS 1409 Grand Ave

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

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.

RESERVED FOR BINDING

