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

Do not use this space.

38733

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11152

City St Louis Mo. (No. 1107 A. Tyler St. ..... St. ..... Ward)

2. FULL NAME Adam Lalak

(a) Residence. No. 1107 A. Tyler. St., 26 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 24 – 1883.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	46.	4	20	

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

9. BIRTHPLACE (CITY OR TOWN) Poland.
(STATE OR COUNTRY)

PARENTS

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

14. INFORMANT Chester Lada
(Address) 1107 Tyler Sta

15. FILED NOV 15 1929 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14th 1929.

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1929, to Nov 14 1929 that I last saw him alive on Nov 13 1929, and that death occurred, on the date stated above, at 11 30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
23A Consumption
73 Pulm. Tuberculosis
..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
..... (duration) ..... yrs. 4 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? Clinical
(Signed) William P Donovan M. D.
Nov 14 1929 (Address) 1943 N 11th St

*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
Calvary.	Nov. 16th 1929
20. UNDERTAKER Aug Brockland L & N Co.	ADDRESS 1421 N. 9 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.

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