

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

4771
Do not use this space.

REC'D MAR 13 1939

791
1003

Registered No. **1464**

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City **St. Louis** (d) Street No. **City Hospital No. 1** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Stanislaw (Steve) Lada**

(a) Residence, No. **1716 North 13th St. 24** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **widowed**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2 / 13 / 39** 19

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

22. I HEREBY CERTIFY, That I attended deceased from **1/30/39**, 19, to **2/13/39**, 19.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 2, 1855.**

I last saw him alive on **2/13/39**, 19. Death is said to have occurred on the date stated above, at **11 a.**
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS **83** MONTHS **7** DAYS **11** If LESS than 1 day, hrs. or min.

Arteriosclerotic heart disease with failure

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. **nil**
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

[Signature]

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Poland**

Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **no**.....

FATHER 13. NAME **Don't know**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Don't know**

MOTHER 15. MAIDEN NAME **Don't know**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Don't know**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT **Hosp. Info M. Kent** (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Feb. 16 1939**

Manner of injury.....
 Nature of injury.....

19. FUNERAL DIRECTOR (NAME) **Brockland Und. Co.** (ADDRESS) **1827 Hogan St.**

24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify.....
 (Signed) *[Signature]*, M. D.
 (Address) **City Hospital #1**

20. FILED **FEB 15 1939** *[Signature]* Local Registrar

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed John B. Brockland
Licensed Embalmer No. 93
P. O. Address St. Louis Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con
with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.