

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

20448
Do not use this space.

1939 JUL 12 1939

1. PLACE OF DEATH

(a) County / Registration District No. **791**
 (b) Township Primary Registration District No. **1008**
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

E 1192 **270**

2. PRINT FULL NAME

(a) Residence, No. **1833 South 11th** **23** (If nonresident, give city or town and State)
 Theresa Laga LYGA

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) **widowed**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Peter Laga**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **? Unknown**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **71**
 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. Data deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Galicia 7**
 13. NAME (Father) **(Unknown) Laga 7**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Galicia 7**
 15. MAIDEN NAME (Mother) **Unknown**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Galicia**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6/12/39** 19
 22. **I HEREBY CERTIFY**, That I attended deceased from **4/26/39** 19, to **6/12/39** 19.
 I last saw him/her alive on **6/12/39** 19. Death is said to have occurred on the date stated above, at **7.20** a.m./p.m.
 The principal cause of death and related causes of importance were as follows:
Uremia
133b
 Other contributory causes of importance:
Cyst of Kidney, non malignant

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?
 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.
 Manner of injury
 Nature of injury
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify **C. U. Mchamara** M. D.
 (Signed) **C. U. Mchamara**
 (Address) **City Hospital No. 1**

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Peter Paul Cem.** DATE **6/14** 19**39**
 19. FUNERAL DIRECTOR (ADDRESS) **Chulick Und. Co.**
1716 S. JEFFERSON
 20. FILER **J. B. Buehler** Local Registrar

JUN 13 1939

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.

MARION—RESERVED FOR BINDING

V. S. 500. 2.
50M-7-20-37
I I X12004

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed J. G. Sullivan
Licensed Embalmer No. 1122

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