

FILED JAN 3 1944
Registration District No. **1345**

Primary Registration District No. **6076**

Registrar's No. **2906**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Jennings**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2109 McLaran Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **51 Years.**
years, months or days

3. (a) PRINT FULL NAME **Andrew Laskowitz**

3. (b) If veteran, name war **XXXXXXXXXX**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Clara Laskowitz**

6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **Nov. 5. 1868**
(Month) (Day) (Year)

8. AGE: Years **75** Months **1** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Kitzee Austria**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Butcher**

11. Industry or business _____

12. Name **Jacob Laskowitz**

13. Birthplace **Austria**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Paradise**

15. Birthplace **Austria**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clara Laskowitz**

(b) Address **2109 McLaran Ave.**

17. (a) **Burial** (b) Date thereof **12/27/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **M. J. ...**

(b) Address **2117 E. Grand Blvd.**

19. (a) **DEC 27 1943** (b) **C. L. McLaran, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **96**

(c) City or town **Jennings**
(If outside city or town limits, write "RURAL")

(d) Street No. **2109 McLaran Ave.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23**
year **1943** hour **8** minute **45** P.M.

21. I hereby certify that I attended the deceased from **Nov 23 1943**
that I last saw him alive on **Dec 23 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **acute dilatation of heart**

Due to **cholesterol**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **C. L. McLaran, M.D.** (M. D. or other) **27**
Address **589 n grand** Date **Dec 27 1943**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

16000

MOTHER FATHER

707

Dr. Finnigan
539 N. Grand. Humboldt Bldg
Fr 6585

JAN 19 1944

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 Frank A. Morris
Licensed Embalmer No. 3041
P. O. Address 2117 E Grand

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.)

If this body is not embalmed, fact should be so stated above.