No. 2
-5-43
-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16514

FILED MAY 25 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4413

1. PLACE OF DEATH:

(a) County ST. LOUIS MO.

(b) City or town ST. LOUIS MO. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6½ hours DE PAUL HOSP. (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000 12 26

(c) City or town ST. LOUIS MO. (If outside city or town limits, write "RURAL")

(d) Street No. 1910 MONTGOMERY STR (If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country NO. 0

3. (a) PRINT FULL NAME RAYMOND LADDA.

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race O WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife ——

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

7. Birth date of deceased APRIL (Month) 15TH (Day) 1935 (Year)

8. AGE: Years 9 Months 0 Days 25 If less than one day —— hr. —— min.

9. Birthplace ST. LOUIS (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation ATTENDING SCHOOL

11. Industry or business ——

FATHER
12. Name ZYGMUNT LADDA.
13. Birthplace ST. LOUIS (City, town, or county) MO. 0 (State or foreign country)

MOTHER
14. Maiden name STELLA TYSKIEWICZ
15. Birthplace ST. LOUIS. (City, town, or county) MO. 0 (State or foreign country)

16. (a) Informant Zygmunt Ladda

(b) Address 1910 Montgomery.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 13-44 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director Brockland Und. Co.

(b) Address 1827 Hogan St.

19. (a) MAY 12 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month MAY day 10TH year 1944. hour 12.30 minute A. M.

21. I hereby certify that I attended the deceased from 5-9-44, 19..., to ..., 19...; that I last saw him alive on 5-9-44, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia — Duration one da.

Due to Fulminating infection of an unknown type.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Septicemia

Meningococcus septicemia

Affected Dr. Corr. 6-1-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work (e) Means of injury

23. Signature Walter H. Spoeneman (M. D. or other)

Address 1506 St. Louis Date signed May 10, 1944.

(Licensed Embalmer's Statement on Reverse Side)

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 Wgonoski

Licensed Embalmer No. 338

P. O. Address.....

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.