

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

Do not use this space.

3323

1. PLACE OF DEATH

County.....  
Township.....  
City *St. Louis* (No. *5600*)

Registration District No. *1791*  
Primary Registration District No. *1003*

File No. ....  
Registered No. *950*  
St. .... Ward)

2. FULL NAME

*Sophie Liszewski (Sophie LISZEWSKI)*

(a) Residence. No. *1406 N. 9th* St. *25* Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 27 - 1915*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<i>12</i>	<i>1</i>	<i>2</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Student*  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Mo*  
(STATE OR COUNTRY)

10. NAME OF FATHER *Walter Liszewski*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Poland*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Aggie Bz Ruszte*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Poland*  
(STATE OR COUNTRY)

14. INFORMANT *Mrs. Liszewski (Aunt)*  
(Address) *2414 S. 18 St.*

15. FILED: *24* 19*28* *Mar C Starckoff* REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan - 24 19 28*

17. I HEREBY CERTIFY That I attended deceased from *Jan 22*, 19*28*, to *Jan 24*, 19*28*, and that I last saw her alive on *Jan 24*, 19*28*, and that death occurred, on the date stated above at *8:30 P. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Meningitis, Meningococci (Epidemic Cerebro-Spinal Meningitis)*

(duration) *0* yrs. *0* mos. *6* da.  
CONTRIBUTORY (SECONDARY) *24* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *1406 N. 9th St*  
IF NOT AT PLACE OF DEATH:

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF

20. WAS THERE AN AUTOPSY? *No*  
WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory*  
(Signed) *George H. Garrison* M. D.  
*1/24/1928* (Address) *Isolation Hospital*

\*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 *Calvary* DATE OF BURIAL *Jan 27 - 19 28*

20. UNDERTAKER *Ang Brockland R & Co* ADDRESS *1421 N. 9th 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

