

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.

NOV 15 1937

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

35902
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791 / 1003 /**
 (b) Township Primary Registration District No. Registered No. **9479**
 (c) City **St. Louis** (d) Street No. **BARNES HOSPITAL** 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.

2. PRINT FULL NAME **Liza Olkienicki**

(a) Residence, No. **74 Paeblank** St. **KA C. Mexico Missouri**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Max Olkienicki**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **ulk**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **ab 44**
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **at home**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date 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) **Wilno Lithuania**
 FATHER 13. NAME **Benzion Lebedun**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Lithuania**
 MOTHER 15. MAIDEN NAME **MARY Rachel JAGON**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Lithuania**
 17. INFORMANT **Abraham Levin**
 (ADDRESS) **7415 York Drive**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Forest Home Cemetery** DATE **10/11/37**
 19. FUNERAL DIRECTOR **H. Burger**
 (ADDRESS) **4215 McAdams**
 20. FILED **OCT 11 1937** **Buebeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10/9/37**
 22. I HEREBY CERTIFY, That I attended deceased from **9-22**, 19**37**, to **10-9**, 19**37**
 I last saw **her** alive on **10-9**, 19**37** Death is said to have occurred on the date stated above, at **3:05** p.m.
 The principal cause of death and related causes of importance were as follows:
Bronchiectasis (bilateral)
Pulmonary Suppuration
 Date of onset **April 1936**
 Other contributory causes of importance: **1065**
 Name of operation **None** Date of
 What test confirmed diagnosis? **X-Ray** Is there an autopsy? **No**
 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? **NO**
 If so, specify
 (Signed) **W. Sullivan** M. D.
 (Address) **BARNES HOSPITAL**

STATEMENT BY LICENSED EMBALMER

I, Herbert A. Berger, Licensed Embalmer No. 1597

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

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Herbert A. Berger
Licensed Embalmer No. 1597

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.)