

REC'D JUN 9 1938

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

791
1003

16583

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. 4444
(c) City St. Louis, Mo (d) Street No. 1320 Sarsfield Pl. 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 Catharine Olszewski

(a) Residence, No. 1320 Sarsfield Pl. St. 31
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Olszewski
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1 1865
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
73 - 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Poland13. NAME J. Olszewski14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland17. INFORMANT Sister Hyacintha Franciscan
(ADDRESS) Order18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE May 16th 193819. FUNERAL DIRECTOR (NAME) Central Und. Co
(ADDRESS) 1841 Cass AV20. FILED MAY 15 1938 J. B. Buehler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 13, 1938

22. I HEREBY CERTIFY That I attended deceased from May 10, 1938, to May 13, 1938
I last saw him alive on May 12, 1938 Death is said to have occurred on the date stated above, at 6:40 a. m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis (Date of onset)

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis? Symptoms Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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 Joseph Olszewski M. D.
(Signed) 1977
(Address) 1977

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

Albert H. Wapner

Licensed Embalmer No. *1861*

P. O. Address

439 N. Canal

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, above space should be left blank.