

S. No. 30
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10538

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3321
Registrar's No.

FILED APR 12 1948

318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County
(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:
5951 Theodore
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 56-7-4 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17
(d) Street No. 5951 Theodore (If rural, give location) 9
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME OLENDER, AGNES

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife SIEVE OLENDER 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased OCTOBER 1 1891
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

12. Name Jacob Laczni 4

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

14. Maiden name unknown

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

16. (a) Informant ALEXANDER OLENDER

(b) Address 5913 Emma St.

17. (a) Burial (b) Date thereof 4-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director St. Louis Fun. Home

(b) Address 2205 St. Louis Ave

19. (a) APR 6 1948 (b) J. J. Prescott
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 4 day 5
year 48 hour 8:30 minute am M.
21. I hereby certify that I attended the deceased from 3-28-48
_____ 19____ to 4-5-48 19____
that I last saw h. 2 alive on 4-4-48
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Myocardial Infarct 3/24/48

Due to _____
Due to PH
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) (c) Means of injury 21
23. Signature Robert E. ... (M. D. or other) DO
Address 329 ... Date signed 4/5/48

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

0
17
9

paid

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 *Ernest W. Spillars*
Licensed Embalmer No. *14080*
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.