RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1960 318

-60-036440

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 9463

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Length of stay in 1b: 1-wk.

c. CITY OR TOWN St.Louis — Inside Limits: Yes [X] No [ ]

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital — Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location) 957 Wilmington Ave. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: John Middle: Last: Olenyik

4. DATE OF DEATH Month: Sept. Day: 25, Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 6/26/04

9. AGE (last birthday): 56

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (City and state or country): New York

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Joseph Olenyik

13b. MOTHER'S MAIDEN NAME: Anna Miller

14. NAME OF HUSBAND OR WIFE: Elizabeth Haich Olenyik

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Mrs John Olenyik Address: 957 Wilmington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 18 MO

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Feb 16, 1960 to Sept 25-60 and last saw her alive on Sept 25-60

Death occurred at 11:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William W Farley (Degree or title) M.D.

22b. ADDRESS 3108 S. Grand

22c. DATE SIGNED 9-27-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Sept. 28, 1960

23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park

23d. LOCATION (City, town, or county) (State): St.Louis County, Missouri

24. FUNERAL DIRECTOR: WACKER-HELDERLE-3634 Gravois Ave.

25. DATE RECD. BY LOCAL REG.: SEP 27 1960

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Clarence M Bill

Licensed Embalmer No. 4375

P. O. Address St Louis 33

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.