

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.

REC'D FEB 10 1939

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

799  
 Do not use this space.

I. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1003**  
 (c) or City **St. Louis.** (d) Street No. **Firman Desloge Hospital.** Registered No. **799**  
 (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.

II. PRINT FULL NAME **Minnie Oliver.**

(a) Residence, No. **7007 Lillian.** St. **NR** **St. Louis, Co. Mo.**  
 (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
Female	White	Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Albert W. Oliver</b>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Oct. 25, 1868.</b>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
60		2	29	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Housewife.</b>			
	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) <b>New York City.</b> (STATE OR COUNTRY) <b>New York.</b>				
FATHER	13. NAME <b>Unknown</b>			
	14. BIRTHPLACE (CITY OR TOWN) <b>Germany</b> (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME <b>Elizabeth Haas.</b>			
	16. BIRTHPLACE (CITY OR TOWN) <b>Germany.</b> (STATE OR COUNTRY)			
17. INFORMANT <b>Albert W. Oliver.</b> (ADDRESS) <b>7007 Lillian.</b>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Memorial Park Cem. Jan. 27, 1939</b>				
19. FUNERAL DIRECTOR (NAME) <b>Stroot Carroll</b> (ADDRESS) <b>4600 Natural Bridge</b>				
20. FILED <b>J. B. Bichuk</b> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 24th, 1939**

22. I HEREBY CERTIFY That I attended deceased from **Dec - 10** to **Jan 24**, 19**39**  
 I last saw him alive on **Jan 24, 1939**. Death is said to have occurred on the date stated above, at **6:25 a.m.**  
 The principal cause of death and related causes of importance were as follows:  
**Congestive heart failure**  
**Pneumonia, heart disease, mitral stenosis & regurg.**

Other contributory causes of importance:  
**Pneumonia, heart disease, mitral stenosis & regurg.**

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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?  
 If so, specify .....

(Signed) **Bernard B. Berman** M. D.  
 (Address) **Firman Desloge Hosp.**

JAN 25 1939

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**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

*Sheldon Collier*

Licensed Embalmer No. *3382*

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, above space should be left blank.**