

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8944**
Registrar's No. **2427**

Registration District No. **791** | Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____ years, months or days)
3. (a) PRINT FULL NAME Genia Cora Della Oliver

3. (b) If veteran, name war No. **3. (c) Social Security** No. None

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married, divorced** Married

6. (b) Name of husband or wife Herbert **6. (c) Age of husband or wife if alive** 57 years

7. Birth date of deceased Feb. 12 1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Caldwell Co. Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { **12. Name** James Groves
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

{ **14. Maiden name** Rebecca Fraley
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert Oliver
(b) Address Canaloe, Mo.

17. (a) Removal _____ **(b) Date thereof** 3-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) MAR 13 1940 **(b)** J. F. Bredich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Canaloe
(If outside city or town limits, write "RURAL.") N.R.
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 13
year 1940 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from Jan. 25 1940
_____ 19 _____ to Mar. 12 1940
that I last saw her alive on Mar. 12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Pyelonephrosis, Bilateral with Multiple Abscesses

Due to _____
Due to _____

Other conditions Portal Cirrhosis, Abscesses Spleen
(Include pregnancy within 3 months of death)
Cellulitis Rt. Side Face

Major findings:
Of operations _____
Of autopsy Same as above

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)
(e) Means of injury _____

23. Signature J. R. Nakada (M. D. or other)
Address Humboldt Bldg **Date signed** 3/12/40

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

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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.

No Embalmed

Signed _____

Licensed Embalmer No. _____

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.