

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17855

State File No. _____

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 493

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1102 S. 9th 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 24 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1102 S. 9th
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

JAMES E. OLIVER 416

8. (b) If veteran, name war none 3. (c) Social Security None

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Oliver 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased Aug. 11th 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Chicago Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Traveling salesman

11. Industry or business Retired

12. Name Amel Oliver

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

14. Maiden name Mary Toopen

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

16. (a) Informant Byron Oliver

(b) Address 1102 S. 9th St. Joseph, Mo.

17. (a) Removal (b) Date thereof May 4, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maryville, Mo.

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph, Mo.

19. (a) May 4 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1940 hour 5 minute 10 a. m.

21. I hereby certify that I attended the deceased from May 2nd #
1940, to _____, 19____

that I last saw #### and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to _____

Due to _____

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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? _____

85 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature BW Tadlock Coroner (M. D. or other) S
Address King Hill Bldg Date signed 5/4/40

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

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

C. G. Swan

Licensed Embalmer No. *4082*

P. O. Address *St. Joseph.*

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.