

FILED MAY 20 1944 18

Registration District No.

1003

Registrar's No.

4422

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

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: BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Macon  
(c) City or town Decatur  
(If outside city or town limits, write "RURAL")  
(d) Street No. 511 W. Prairie  
(If rural, give location) N.R.  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country L

3. (a) PRINT FULL NAME HAROLD EUGENE OLIVER

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

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

6. (b) Name of husband or wife Vera Oliver 6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased January 29 1920  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
24 3 12 hr. min.

9. Birthplace Springfield Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

12. Name Unknown  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Ade Unknown  
15. Birthplace Lancaster City Pa.  
(City, town, or county) (State or foreign country)

16. (a) Informant Vera Oliver  
(b) Address Decatur, Ill.

17. (a) Removal (b) Date thereof 5-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Altamont, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 15 1944 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11  
year 1944 hour 10.0 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 10, 1944, to May 11, 1944  
that I last saw h. m. alive on May 11, 1944  
and that death occurred on the date and hours stated above.

Immediate cause of death Chronic Myelogenous Leukemia Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature John H. Ehrenbaum (M. D. or other) MO  
Address BARNES HOSPITAL Date signed

MAY 12 1944

MAR 2 1948

**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 John Gonoski  
Licensed Embalmer No. 3398  
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.**