

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 3 3 yrs 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4215 Vista 18
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Mary Oliver

(b) If veteran, name war nil (c) Social Security No. nil

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Samuel Amy 6. (c) Age of husband or wife if alive 12 years 1883 (Year)

8. AGE: Years 61 Months 3 Days 4 If less than one day hr. min.

9. Birthplace St. Louis County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Nurse wife

11. Industry or business

12. Name John Henry Taylor
13. Birthplace Tenn (City, town, or county) (State or foreign country)
14. Maiden name Emma Hicks
15. Birthplace Ark (City, town, or county) (State or foreign country)

16. (a) Informant William S. Taylor

(b) Address 2008 Benton Grand City, Ill

17. (a) Burial (b) Date thereof Nov 18-44 (Month) (Day) (Year)

(c) Place: burial or cremation My Memorial Park

18. (c) Signature of funeral director Guy Miller

(b) Address 5041 Delmar

19. (a) Nov 2 (b) J. F. Predeck (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16th year 1944 hour 4:40 minute A. M.

21. I hereby certify that I attended the deceased from 11/11/44 to Nov. 16th 1944 that I last saw her alive on Nov. 16th 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration

Due to Hypertension
Due to 82

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

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

23. Signature E. W. C. [Signature] 1515 Lafayette (M. D. or other) 11/16/44 (Date signed)

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

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

MOTHER FATHER

0986

0986

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 J. Fetter
Licensed Embalmer No. 3880
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.