

S. No. 2
M-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29300**
Registrar's No. **8083**

Registration District No. **318** 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:
5637 Wabada Ave.
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 176
(d) Street No. 5637 Wabada Ave.
(If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James A. Oliver
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Julia Oliver 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Sept. 14 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 15
year 1945 hour 10 minute 30 P. M.
21. I hereby certify that I attended the deceased from Sept 14 1945
_____, 19____, to Sept 15, 1945;
that I last saw him _____ alive on Sept 15, 1945,
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
74 0 1 _____ hr. _____ min.

Immediate cause of death _____
Angina pectoris
Due to atherosclerosis of coronary artery
Due to _____

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo.
10. Usual occupation Barber
11. Industry or business Self
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

Other conditions _____ (include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Vernas Jolliff
(b) Address 5637 Wabada Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 1945
(Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) SEP 17 1945 (b) [Signature] (Date received local registrar) (Registrar's signature)

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? No
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. Spizzini (M. D. or other) M. D.
Address 1638 1/2 Blvd Date signed 9.16.45

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 Warren A. Carver

Licensed Embalmer No. 3534

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.