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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 7 1945 STANDARD CERTIFICATE OF DEATH

State File No. **32838**
Registrar's No. **4353**

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 900 E. 11th 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Merit Edwin Oliver

3. (b) If veteran, name war no 3. (c) Social Security 493-18-1041

4. Sex M-O 5. Color or race Wh 6. (a) Single, widowed, married, divorced M-1
6. (b) Name of husband or wife Grace 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Nov-22-1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 10 29 hr. min.

9. Birthplace Danvers N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation Meat Cutter

11. Industry or business _____

12. Name John Oliver

13. Birthplace N.Y.
(City, town, or county) (State or foreign country)

14. Maiden name Wright

15. Birthplace N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Grace Oliver
(b) Address 900 E. 11th

17. (a) Burial (b) Date thereof 10-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bainard Mo

18. (a) Signature of funeral director Hallyn Roe

(b) Address 7408 Wornall Rd.

19. (a) 10-23-45 (b) Sheladine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21
year 1945 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 18, 45 to October 21, 1945
that I last saw him alive on October 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death adenocarcinoma of tongue with metastasis

Due to _____
Due to _____

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

Major findings: 45 hr
Of operations _____
Of autopsy _____

Duration
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? _____

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

23. Signature Clark W. Seelye MD
Address Med. Dir. K.C. General Hospital

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

MOTHER FATHER

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. 2748
working under my personal supervision.

Signed Howard G. Roe

Licensed Embalmer No. 2748

P. O. Address. 7400 Wornall Rd.

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.