S. No. 2
OM—5-43
v. 5-17-39
I X366

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28940

FILED AUG 29 1946

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7293

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G Phillips Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days (Specify whether years, months or days)

In this community 27 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 2209 Spruce (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

020
2 2 17
9
0

3. (a) PRINT FULL NAME Jessie Oliver

3. (b) If veteran, name war None

3. (c) Social Security No. Unk.

4. Sex Male 2

5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eugenia Oliver

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Abt. 1897 (Month) (Day) (Year)

8. AGE: Years Abt. 49 | Months | Days | If less than one day hr. min.

9. Birthplace Artesia (City, town, or county) Miss (State or foreign country)

10. Usual occupation Boilermaker

11. Industry or business

FATHER
12. Name Miles Oliver, Sr.
13. Birthplace Artesia (City, town, or county) Miss (State or foreign country)

MOTHER
14. Maiden name Emily Harris
15. Birthplace Artesia (City, town, or county) Miss (State or foreign country)

16. (a) Informant Eugenia Oliver

(b) Address 2209 Spruce St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/22/46 (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis, Ill

18. (a) Signature of funeral director R. M. C. Green

(b) Address 3517 Laclede Ave

19. (a) AUG 22 1946 (Date received local registrar) (b) J. F. Brezeak (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20 year 1946 hour 7 minute 55 A.M.

21. I hereby certify that I attended the deceased from 8-1, 1946, to 8-20, 1946 that I last saw him alive on August 20, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumoconiosis	Undet.
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Yes

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 of injury 0

23. Signature E. B. Williams (M. D. or other)

Address 2601 N Whittier Date signed 8/22/46

(Licensed Embalmer's Statement on Reverse Side)

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 Melvin Edward Green, Registered Apprentice No. 383, working under my personal supervision.

Signed C. T. Nash

Licensed Embalmer No. 2432

P. O. Address 3847 Page

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.