

No. 2
-1/47
-17-39

25750

FEDERAL BUREAU OF INVESTIGATION

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

U.S. Department of Health and Human Services
Bureau of Vital Statistics
FILED SEP 23 1947

Registrar's No. 1852

Registration District No. 3177

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days (Specify whether
In this community 27 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 917 Truesdale
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Dinia Tolliver
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Alfred 6. (c) Age of husband or wife if alive 5 years
7. Birth date of deceased 10 5 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 10 19 hr. min.

9. Birthplace Fort Smith Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Robert Turner

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

14. Maiden name Jane ?

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

16. (a) Informant Maggie Green

(b) Address 917 Truesdale

17. (a) Burial (b) Date thereof 5-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director C. J. Nash

(b) Address 3847 Poplar

19. (a) 8-18-47 (b) Chula J. Kuyper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1947 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from August 7 1947 to August 24 1947
that I last saw her alive on August 24 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Heat stroke? Duration 19 days

Due to.....

Due to..... 191

Due to..... 191

Other conditions Hypertensive Cardiovascular disease
(Include only those conditions which were present within 3 months of death)

Generalized Atherosclerosis, Bronchopneumonia

Major findings: Of operations.....

Of autopsy None Obtained.

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?..... (c) Means of injury.....

23. Signature P. Herdines (M. D. or other) 0

Address 601 Brentwood Blvd Date signed 8/25/47

WRITE PLAINLY—USING 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 C. J. Nash, Registered Apprentice No. _____ working under my personal supervision.

Signed C. J. Nash

Licensed Embalmer No. 2482

P. O. Address 3847 Page Pl

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.

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:
 (a) County St Louis
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (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)

3. (a) PRINT FULL NAME Vinia Toliver
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased Oct 5 (Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Stenographer

11. Industry or business _____

MOTHER {
 12. Name _____
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Day _____ Year 1947 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
 Due to _____
 Other conditions _____ (include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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) (e) Means of injury _____

23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

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

STIPPLEMENTARY

SEP 26 1967

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