

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9948

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2579**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5795 Pershing		d. STREET ADDRESS (If rural, give location) 5795 Pershing	

3. NAME OF DECEASED (Type or Print) a. (First) Fide	b. (Middle)	c. (Last) Canoll	4. DATE OF DEATH (Month) (Day) (Year) March 18, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Feb. 26, 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New Orleans, La. /	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Cyrus W. Oliver	13b. MOTHER'S MAIDEN NAME Fide Jinks	14. NAME OF HUSBAND OR WIFE Harry N.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Gladys Hoolan, 5795 Pershing
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease		2 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anemia due to undetermined cause		2 mos.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 5:30 AM	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Heart
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22. I hereby certify that I attended the deceased from **May 19 49** to **Mar 18 1951**, that I last saw the deceased alive on **Mar 17, 1951**, and that death occurred at **5:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Richard G. Jones, M.D.	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 19 Mar 51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-20-51	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAR 19 1951	REGISTRAR'S SIGNATURE J. B. Lanter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *Robert M Murray*

Licensed Embalmer No. *3749*

P. O. Address *St Louis, Mo*

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.