

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35791

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 93111

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY 2219	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION. 1908 Biddle		e. STREET ADDRESS (If rural, give location) 21 1908 Biddle St	

3. NAME OF DECEASED (Type or Print) a. (First) Olphelia b. (Middle) Oney c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Oct 10, 1954		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 28, 1877	9. AGE (In years last birthday) 77	10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours	12. UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and State or Foreign Country) Poon Toop Miss.		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Peter Flemming		13b. MOTHER'S MAIDEN NAME Dapha Simmons		14. NAME OF HUSBAND OR WIFE Henry Oney			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jane Reid 3848 Greer			
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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, asthma, 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) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Senility							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 4500	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 830 A. M., from the causes and on the date stated above.

23a. SIGNATURE Patrick J. Taylor Coronar		23b. ADDRESS 1300 Clark Ave		23c. DATE SIGNED 10.13.54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-15-1954		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County MO	
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DATE REC'D BY LOCAL REG. OCT 13 1954		REGISTRAR'S SIGNATURE H. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Mose Vasser		ADDRESS 2812 Cass	
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Leroy W. Emmert

Licensed Embalmer No. 450

P. O. Address 3880 E

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**