

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35041

FILED OCT 24 1955

State File No. ....

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 8925

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8925		
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 town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				STREET ADDRESS (If rural, give location) 12 4738 Lewis Place 21290				
3. NAME OF DECEASED (Type or Print) Hollie			a. (First)		b. (Middle)		c. (Last) Oliver	
4. DATE OF DEATH		(Month) 10		(Day) 10		(Year) 55		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Married (Specify)		8. DATE OF BIRTH 3-20-1886		
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 6		IF UNDER 1 HR. Days 20		IF UNDER 1 HR. Hours Min.		
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 (City and State or Foreign Country) Lexington, Mis s.		
12. CITIZEN OF WHAT COUNTRY? U.S.				13a. FATHER'S NAME James McGee		13b. MOTHER'S MAIDEN NAME Lue Johnson		
14. NAME OF HUSBAND OR WIFE Henry Oliver				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		
17. INFORMANT'S SIGNATURE OR NAME Henry Oliver				ADDRESS 4738 Lewis Pl.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous Arthritis of Lumbar Spine				INTERVAL BETWEEN ONSET AND DEATH Wndt.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____						
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia Generalized Arteriosclerosis						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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) _____		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? _____				
22. I hereby certify that I attended the deceased from 5-2, 1955, to 10-12, 1955, that I last saw the deceased alive on 10-12, 1955, and that death occurred at 9:10a m., from the causes and on the date stated above.								
23a. SIGNATURE Edw. B. Williams (Degree or title) M.D.				23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 10-13-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIED		24b. DATE 10-13-55		24c. NAME OF CEMETERY OR CREMATORY Shipped to Durant, Mississippi		24d. LOCATION (City, town, or county) (State) on 10-14-55		
DATE REC'D BY LOCAL REG. OCT 13 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Peoples Und. Co.		ADDRESS 3100 Franklin		

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

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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 *H. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *45750*

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.