

Health,  
Welfare  
Public  
Service

FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

196988  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1201

300  
156

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Riverview Gardens</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Riverview Gardens</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>422 Scenic Dr.</u>		Length of stay in lb <u>14 yrs.</u>	d. STREET ADDRESS <u>422 Scenic Dr.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Virgil</u>			4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 8, 1912</u>		9. AGE (In years last birthday) <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement</u>		11. BIRTHPLACE (City and state or country) <u>Columbus, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John F. Olmsted</u>			14. MOTHER'S MAIDEN NAME <u>Blanche Irwin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-07-9797</u>		17. INFORMANT Address <u>Mrs. Eloise Olmsted, 422 Scenic Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) <u>Cardiovascular Disease</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			20d. INJURY OCCURRED... WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>12-2-57</u> to <u>5-8-57</u> and last saw <u>him</u> alive on <u>5-1-57</u> Death occurred at <u>4:00</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. E. Morrison MD</u> (Degree or title)			22b. ADDRESS <u>4110 W. Flamingo Ave</u>		22c. DATE SIGNED <u>5-8-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>5/10/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
24. FUNERAL DIRECTOR <u>Drehmann-Harral</u>		ADDRESS <u>1905 Union</u>		25. DATE RECD. BY LOCAL REG. <u>5-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Donk MD</u>

97

Dr. Harvey Morris  
4110 W. Florissant  
Ev. 1-8824

Hrs. 2:30 - 6:30 Wed.

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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 *Warren A. Carver*.....

Licensed Embalmer No. 39

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.