THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003347 STATE FILE NUMBER 2 695

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED FEB 4 1959

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Alexian Bros. Hosp. — Length of stay in 1b: life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis 2169 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3628a Winnebago St. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: ADOLPHUS Middle: J. Last: OLOFF

4. DATE OF DEATH Month Day Year: Jan. 18, 1959.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Nov. 20, 1906

9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Mail

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Adolphus Oloff

13b. MOTHER'S MAIDEN NAME: Anna Doran Oloff

14. NAME OF HUSBAND OR WIFE: Rose Rosales Oloff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 500-42-0982

17. INFORMANT Address: Mrs. Rose Oloff, 3628a Winnebago St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CEREBRO-VASCULAR HEMORRHAGE	3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	HYPERTENSIVE CARDIOVASCULAR DISEASE	UNK
DUE TO (c)	443 X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1-16-59, to 1-18-59 and last saw ~~him~~ him alive on 1-18-59. Death occurred at 6:25 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Henry J. Cooper MD

22b. ADDRESS: 818 Olive St.

22c. DATE SIGNED: 1/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan.21,1959

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Beiderwieden F.H.,Inc,1936 St.Louis Av.

25. DATE RECD. BY LOCAL REG.: JAN 21 '59

26. REGISTRAR'S SIGNATURE: J Carl Smith MD

mJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 452

P. O. Address St Louis

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