

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003885

FILED VS. FEB 10 1960

2 1112

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in 1b 80 yrs	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Nursing Home		d. STREET ADDRESS (If outside, give location) 3863 West Pine	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Clair Middle D. Last Oldham			4. DATE OF DEATH Month January Day 30, Year 1960			
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1871	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal		10b. KIND OF BUSINESS OR INDUSTRY Edwin Guth Co.		11. BIRTHPLACE (City and state or country) Cuba, N.Y.		12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME George N. Oldham		13b. MOTHER'S MAIDEN NAME Mary Etta Keller		14. NAME OF HUSBAND OR WIFE Pauline	
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. 491-16-8075		17. INFORMANT Dorothy Palmer Address 3863 West Pine Blvd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis General + Cerebral	10 years +
	DUE TO (c) 33 fx	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Possible Terminal Pneumonia - 5 days Osteomyelitis Fracture Fibula - 20 years		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 Month, Day, Year		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 **1938**, to **1-30-60** and last saw him alive on **1-26-60**
 Death occurred at **7:10 AM.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. H. [Signature]		22b. ADDRESS 804 Hamilton Blvd St. Louis 12 Mo		22c. DATE SIGNED 1-30-60
23a. BURNAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 7-7-1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR Catharine J. [Signature]		25. DATE RECD. BY LOCAL REG. FEB 1 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

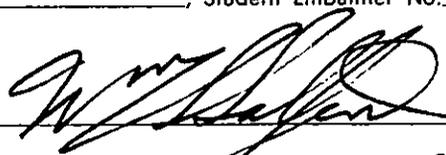
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 469
P. O. Address. 384

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