

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... **District** Primary Registration District No. **1003**
 City..... (No. **637**) **Elizabeth Ave**

File No. **15634**
 Registered No. **4060**
 St. Ward)

2. FULL NAME

(a) Residence. No. **637 Elizabeth Ave** **3** Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **MARRIED**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Agnes Burke Oliver**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 22nd 1890**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	40	3	9	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Teamster 104**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **INDIANA**

10. NAME OF FATHER **Adam Oliver**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **INDIANA**

12. MAIDEN NAME OF MOTHER **MARY Forsythe**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **INDIANA**

14. INFORMANT **Agnes Burke Oliver**
 (Address) **637 Elizabeth Ave**

15. FILED **May 19 1931** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 1st 1931**
 17. **No Physician in Attendance**
 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at **4:00 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Gastric Dilatation
126713
118C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Chronic Cholecystitis**
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH DATE OF
 WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) **[Signature]** M.D.

4/27 1931 (Address) **Deputy Coroner**
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Oakway** DATE OF BURIAL **April 4 1931**

20. UNDERTAKER **Wm. J. Geraghty & Son** ADDRESS **4259 Lindell**

WRITE PLAINLY, WITH OBTAINING INSTRUMENTS TO BE OBTAINED FROM THE BOARD OF HEALTH

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

