

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

12972

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3174

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer G Phillips
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 18 days
 (Specify whether
 In this community Unknown
 years, months or days)

3. (a) PRINT FULL NAME Barbara Jean Toliver 416

3. (b) If veteran, name war XX 3. (c) Social Security No. XX

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife XXX 6. (c) Age of husband or wife if alive XX years

7. Birth date of decedent October 13th, 1938.
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>5</u>	<u>19</u>	hr. _____ min.

9. Birthplace St Louis, Missouri.
 (City, town, or county) (State or foreign country)

10. Usual occupation Infant,

11. Industry or business XXX

12. Name Ren L. Toliver,

13. Birthplace St Louis, Missouri.
 (City, town, or county) (State or foreign country)

14. Maiden name Alice Goddy,

15. Birthplace Ark,
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Barbara Toliver

(b) Address 2722 Walnut, St. St. Louis, Mo.

17. (a) Burial, (b) Date thereof 4-6-40.
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park,

18. (a) Signature of funeral director [Signature]

(b) Address 2812, Thomas, St. St. Louis, Mo.

19. (a) APR 5 1940 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 22
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2722 Walnut
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
 year 1940 hour 6:50 minute _____ A. M.

21. I hereby certify that I attended the deceased from March 14, 1940, to April 1, 1940;
 that I last saw her alive on April 1, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Pneumococci Meningitis
 Due to _____
 Due to _____

Duration
2 wks
2 wks

Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
 Underlines the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address 2601 N Whittier Date signed _____

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

FORM 1 X-9311

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.

STATEMENT BY LICENSED EMBALMER

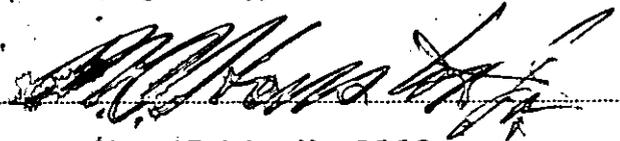
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Myself

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



..... Licensed Embalmer No. 2266.....

P. O. Address. 2812 Thomas, St Louis, Mo.

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 this body is not embalmed, above space should be left blank.