

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30757**
Registrar's No. **8034**

Registration District No. **791** Primary Registration District No. _____

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: **BARNES HOSPITAL**
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution **4 days** (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Guy W. Oliver**
8. (b) If veteran, name war **none** 8. (c) Social Security No. **493-07-759**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **married**
6. (b) Name of husband or wife **Leah Van Riper** 6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **Aug 16th 1887**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 **1** **10** hr. _____ min.

9. Birthplace **Niagara on the lake Canada**
(City, town, or county) (State or foreign country)

10. Usual occupation **Automobile Dealer**

11. Industry or business **Oliver Cadillac Co**

MOTHER FATHER { 12. Name **Fielding W. Oliver**

18. Birthplace **Cinn Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Ann Williamson**
(City, town, or county) (State or foreign country)

15. Birthplace **Cinn Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Brooke Payne**

(b) Address **423 Lake Ave.**

17. (a) **Burial** (b) Date thereof **Sept 27 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine**

18. (a) Signature of funeral director **Wagoner Und Co**

(b) Address **3621 Olive St**

19. **SEP 26 1940** (b) **J. P. ...**
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____
(c) City or town **St. Louis County NR**
(If outside city or town limits, write "RURAL")
(d) Street No. **600 SOUTH PRICE ROAD**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **26**
year **40** hour **12 25** minute **A** M.

21. I hereby certify that I attended the deceased from **9**
23, 19**40**, to **9-26**, 19**40**;
that I last saw him alive on **9-26**, 19**40**,
and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchogenic carcinoma, rt lung**
Duration **3 Mon's**

Due to _____

Due to _____

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

Major findings: **Bronchogenic carcinoma rt lung**
Of operations _____
Of autopsy _____

PHYSICIAN

Underline 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) Manner of injury _____
23. Signature **J. P. ...** (M.D. or other) _____
Address **BARNES HOSPITAL** Date signed **9-26-40**

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

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.

see affidavit # 287 in ...

MAY 12 1942

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

Robert T. Sangster

Registered Apprentice No. 256

working under my personal supervision.

Signed

Neville B. Holwitt

Licensed Embalmer No. 3696

P. O. Address 3621 Olive St.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8034

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: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME GUY W. OLIVER

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

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

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) OCT. 8, 1940 (b) J. J. Brodbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month SEPT. day 26
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

BRONCHOGENIC CARCINOMA
RT. LUNG

Duration

3 Mos.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

S-30757

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.