

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

33582
State File No. 8279
Registrar's No.

NOV 16 1940
Registration District No. 791

Primary Registration District No.

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

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 Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 hrs 20 min
(Specify whether years, months or days)

In this community 5 years

8. (a) PRINT FULL NAME Martha Oliver

3. (b) If veteran, name war _____

8. (c) Social Security No. None

4. Sex Female

5. Color or race Col.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Boston Oliver

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased August 25 1903
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>37</u>	<u>1</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER {

12. Name Jide Ruth

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

14. Maiden name Unknown

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

16. (a) Informant Boston Oliver

(b) Address 2112 Division

17. (a) Burial Greenwood
(Burial, cremation, or removal)

(b) Date thereof 10-5-40
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Benned Love

(b) Address 3103 Washington

19. (a) OCT 4 1940 (b) J. H. [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 2112 Division
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1940 hour 5:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 28, 1940, to Sept 29, 1940
that I last saw her, alive on Sept 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Prob 3 days
Duration

Due to _____

Due to _____

Other conditions [Handwritten Signature]
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

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? _____

23. Signature J. W. Johnson (M. D. or other) _____
Address 2601 N. Whittier Date signed 9/30/40

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

Malvin Blackman

Licensed Embalmer No. 3962

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.