

S. No. 2
M-5-43
5-17-39
I X3867

FILED NOV 4 1947

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Jackson City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1114 Research Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10-5-47-10-18-47**
(Specify whether)

In this community **57 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

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

(d) Street No. **614 Forest**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **COLOGERO OLIVER**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Male**

5. Color or race **W**

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

6. (b) Name of husband or wife **Rose Oliver**

6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Dec 2 1876**
(Month) (Day) (Year)

8. AGE: Years **70** Months **10** Days **11** If less than one day hr. min.

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

10. Usual occupation **Retired**

11. Industry or business **Henry Oliver**

12. Name **Henry Oliver**

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

14. Maiden name **Rosaria Mellazzo**

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

16. (a) Informant **Rose Oliver**

(b) Address **614 Forest**

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **10/22/47**
(Month) (Day) (Year)

(c) Place: burial or cremation **St Mary's**

18. (a) Signature of funeral director **W. J. ...**

(b) Address **12 ...**

19. (a) **10-21-47** (b) **Ernestine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **18** year **1947** hour **11:50** minute **7** M.

21. I hereby certify that I attended the deceased from **Oct 7** **5:10** to **10-18** **1947** that I last saw him alive on **10-18** and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Thrombosis
arterio sclerosis
Diabetes

Due to _____

Due to _____

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

PHYSICIAN

Major findings: Of operations **no**

Of autopsy **no**

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) (c) Means of injury _____

23. Signature **Dr. Montgomery** Date signed **10/21/47**
Address **12 ...**

Dr. Jan Montgomery
Professional Bld

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 *John B. Lester*
Licensed Embalmer No. *4773*
P. O. Address *KC*

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, fact should be so stated above.