

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3171

State File No.

0769

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8949 Goodfellow		d. STREET ADDRESS (If rural, give location) 1958 Provenchere Pl.	

3. NAME OF DECEASED (Type or Print)	a. (First) Florence	b. (Middle)	c. (Last) Oliver	4. DATE OF DEATH (Month) (Day) (Year)
				1/23/52

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 18, 1896	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME George DeMand	13b. MOTHER'S MAIDEN NAME Anna Zimmerly	14. NAME OF HUSBAND OR WIFE Albert
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME Albert Oliver--	ADDRESS 1958 Provenchere Pl.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES		
	DUE TO (b) Gastric Carcinoma metastatic in kidney & colon		14 months
	DUE TO (c) Cardiovascular		2 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 157X
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22. I hereby certify that I attended the deceased from **Jan 6, 1951**, to **Jan 20, 1952**, that I last saw the deceased alive on **Jan 22, 1952**, and that death occurred at **9:50a.m.**, from the causes and on the date stated above.

23a. SIGNATURE W. S. Sainsbury (Degree or title) M.D.	23b. ADDRESS 3548 Sidney	23c. DATE SIGNED 1-24-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/26/52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. JAN 25 1952	REGISTRAR'S SIGNATURE Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Helderte	ADDRESS 3634 Gravois
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 2675

P. O. Address 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, fact should be so stated above.