

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32071**
Registrar's No. **8091**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1008**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE Missouri c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		e. STREET ADDRESS (If rural, give location) 4214 W. EVANS	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital					

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Ollie	b. (Middle)	c. (Last) Oliver	(Month) 8	(Day) 31	(Year) 54

5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 2-27-1892	9. AGE (In years last birthday) 62	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Hours	12. UNDER 1 MIN. Min.
-----------------------	------------------------------------	--	--------------------------------------	--	----------------------------	----------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY INSURANCE	11. BIRTHPLACE (City and State or Foreign Country) Brookville - Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	--

13a. FATHER'S NAME ALLEN OLIVER	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 486-03-1336	17. INFORMANT'S SIGNATURE OR NAME Alice Umphries	ADDRESS 4214 W. EVANS
---	---	--	---------------------------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infarction of Myocardium		INTERVAL BETWEEN ONSET AND DEATH Undt.
	ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic Coronary Thrombosis		
	DUE TO (c) Hypertensive Cardiovascular Disease Organic Brain Disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
--	--	---

22. I hereby certify that I attended the deceased from **8-26**, 19**54**, to **8-31**, 19**54**, that I last saw the deceased alive on **8-31**, 19**54**, and that death occurred at **1:35 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE H. J. Erwin	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 9-1-54
--------------------------------------	----------------------------------	---	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 9-5-54	24c. NAME OF CEMETERY OR CREMATORY GREENWOOD	24d. LOCATION (City, town, or county) (State) St. Louis County MO
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. SEP 2 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ELLIS FUNERAL HOME	ADDRESS 2820 Stoddard
---	--	---	---------------------------------

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.....
Signature of Student Embalmer

Signed *Fuller E. Cull*

Licensed Embalmer No. *4198*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.