

FILED NOV 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35228
Registrar's No. 9324

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 9324	
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) ST. LOUIS			c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		
d. FULL NAME OF HOSPITAL OR INSTITUTION 4428 GREER AVE			d. STREET ADDRESS (If rural, give location) 4428 GREER AVE		
3. NAME OF DECEASED (Type or Print)		a. (First) MAYOLA	b. (Middle) TOLIVER	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 10 24 55
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 6-10-1899	9. AGE (In years last birthday) 56	10. UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) JACKSON MISS.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME CHARLIE CARTER		13b. MOTHER'S MAIDEN NAME REBACCA CARTER		14. NAME OF HUSBAND OR WIFE BENN TOLIVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MARY L BARBERY, 4428 GREER AVE	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma sigmoid colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 37 months
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 153X			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10.4.55 to 10.10.55, that I last saw the deceased alive on 10.10.55 and that death occurred at 5:10 P.M., from the causes and on the date stated above.					
23a. SIGNATURE <u>R. P. Barrett M.D.</u>			23b. ADDRESS 5086 Easton Ave		23c. DATE SIGNED 10.25.55
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 10-29-55	24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.
DATE REC'D BY LOCAL REG. OCT 25 1955		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. MCCLENDON 4535 WASHINGTON	

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

John K. Cunningham

Licensed Embalmer No. *4972*

P. O. Address *4700 Hammett*

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.