

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46173
STATE FILE NUMBER
12156

FILED DEC 30 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 12156

Health,
& Welfare
Public
Services

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>INCARNATE WORD HOSPITAL</u>			Length of stay in 1b <u>8 WEEKS</u>	d. STREET ADDRESS (If outside, give location) <u>3612 LAFAYETTE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES McDONALD OLIVER</u>			4. DATE OF DEATH <u>DEC 17 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15 1886</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOW BUSINESS</u>	11. BIRTHPLACE (City and state or country) <u>WESSON MISSISSIPPI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES McDONALD OLIVER</u>			14. MOTHER'S MAIDEN NAME <u>EUGENIA ROGERS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-38-7567</u>	17. INFORMANT Address <u>M. THOMAS BALLOWE 3854 BOWEN ST.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency + Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease - 10 yrs</u> DUE TO (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sustained Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420-0</u>			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>12-14-57</u> to <u>12-16-57</u> and last saw <u>him</u> alive on <u>12-16-57</u> . Death occurred at <u>12-17-57</u> <u>10:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Physician or M.D.) <u>W. B. Meyer M.D.</u>			22b. ADDRESS <u>684 N. Grand Blvd.</u>		22c. DATE SIGNED <u>12-17-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>DEC 20 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>KRON UNDERTAKING CO</u> <u>2707 N. Grand</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 18 57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> <u>ms</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Gustav W. Decker*

Licensed Embalmer No. *432*

P. O. Address *St. Paul*

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.