

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

34081

1. PLACE OF DEATH

County Jackson Registration District No. 400 File No. _____
 Townshp. Prarie Primary Registration District No. 3300 Registered No. 178
 City Rockport No. Jackson Co Farm St. _____ Ward _____

2. FULL NAME

R. J. Oldham
 (a) Residence. No. Jackson Co Farm St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Bell Oldham

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 12-1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Richard Oldham

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Nancy Webb

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

14. INFORMANT J. W. Hastetter
 (Address) Jackson Co. Home

15. Geo. H. James
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to Oct 23, 1929 but I last saw him alive on 10/27/29, 1929 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
9:00

(duration) yrs. mos. ds. 2

CONTRIBUTORY General infection
 (SECONDARY) (duration) yrs. mos. ds. 2

18. WHERE WAS DISEASE CONTRACTED Mo
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) J. W. Greene, M. D.
10/9 . 1929 (Address) Independence Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Duckman Cemetery DATE OF BURIAL Oct 24 1929

20. UNDERTAKER Rose & Henderson ADDRESS 157 Jacks

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Low 1/2

1/2