

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

Do not use this space.

11100

File No. _____
Registered No. _____
St. 14 Ward)

1. PLACE OF DEATH
82 County Pike
Township Sumner
City _____ (No. _____)

Registration District No. 648
Primary Registration District No. 5912

2. FULL NAME Manual Olebeare
(a) Residence. No. _____ 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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Zola Hobb Olebeare
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 - 1895
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
36 7 23

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

9. BIRTHPLACE (CITY OR TOWN) Monroe La,
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Victor L. Olebeare
11. BIRTHPLACE OF FATHER (CITY OR TOWN) La
(STATE OR COUNTRY) Orleans
12. MAIDEN NAME OF MOTHER Esther Haught
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pike Co,
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs. Esther Olebeare
(Address) Sumner, Mo.

15. FILE # 41036 WR Sumner, Mo.
REGISTER

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-27-1931
17. I HEREBY CERTIFY, That I attended deceased from 3-24-31 to 3-27-1931, and that I last saw her alive on 3-27-1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
130 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Acute Nephritis (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED 108
IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? (11)

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. H. Wilson, M. D.
, 19 (Address) Bowling Green 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 Louisville Cemetery DATE OF BURIAL 3-29-1931

20. UNDERTAKER Grace Bonhead ADDRESS Bowling Green Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 25 1931

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

684

1. PLACE OF DEATH.

County Pike
 Township Quinn
 City (No.) St. Ward)

Registration District No. 6888
 Primary Registration District No. 5912

File No.
 Registered No. 14

2. FULL NAME Manual Olebeane

(a) Residence No. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 27 1931

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

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw him since on 19....., and that death occurred, on the date stated above, at m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 - 1895

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 7 23

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

*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.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED H/1031 W/S Summers REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-11100