

TYPE PRINTING, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. E.—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.

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

Dr Chapman

22905  
Do not use this space.

REC'D JUL 14 1939

**1. PLACE OF DEATH**

(a) County Remiscot <sup>2</sup> Registration District No. 605  
 (b) Township Madison <sup>1</sup> Primary Registration District No. 3872  
 (c) City Holland or (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 1 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 25, 1863.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
74 7 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Camden (STATE OR COUNTRY) Tenn

FATHER 13. NAME Jack Oatsfall

14. BIRTHPLACE (CITY OR TOWN) Camden (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Ida Lupper

16. BIRTHPLACE (CITY OR TOWN) Camden (STATE OR COUNTRY) Tenn

17. INFORMANT W. S. Green (ADDRESS) Steele, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Zion Cem. DATE June 23 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) \_\_\_\_\_

20. FILED 7/15 W. S. Robinson 587 (Address) \_\_\_\_\_  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23, 39 19

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 1:00 a.m.

The principal cause of death and related causes of importance were as follows:

\_\_\_\_\_ Date of onset \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? 5  
 If so, specify \_\_\_\_\_ (Signed) Dr. Chapman M. D.

2006

RECEIVED

District Health Officer No. 3,

District File Number 739-417

Date Filed 7/10/39

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

22905  
Do not use this space.

1. PLACE OF DEATH

(a) County Peru Registration District No. 6557  
 (b) Township Virginia Primary Registration District No. 2872  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Green Oatsfall

(a) Residence, No.  St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 7 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7/1 1939 L. O. Oakes Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-23, 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on ..... 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

High Blood pressure  
Chronic Brights disease  
 Other contributory causes of importance: 151

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) L. O. Oakes

(Address) Local Registrar

June 260

SUPPLEMENT

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

