

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

32948
Do not use this space.

1. PLACE OF DEATH

(a) County Maxion / Registration District No. 547
 (b) Township Masson / Primary Registration District No. 3029
 (c) City Hannibal / (d) Street No. Leveering Hospital 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 William H. Oldridge

(a) Residence, No. 120 Bix 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** Divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 19 - 1879
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 11 3
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. laborer
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) Jacksville, Ill

FATHER
13. NAME James W. Oldridge
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER
15. MAIDEN NAME Elizabeth Self
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) Thomas Oldridge, Caberwood, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Riverside Cem **DATE** Sept. 19 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James W. Oldridge, Hannibal, Mo

20. FILED Sept 20, 1939 H. C. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 16 - 1939
22. I HEREBY CERTIFY, That I attended deceased from June, 1939, to Sept 16, 1939
 last saw him alive on Sept 16, 1939 Death is said to have occurred on the date stated above, at 10 m.
 The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis
 Other contributory causes of importance: 22
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? no

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) B. H. Murphy, M. D.
 (Address) Hannibal, Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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.