DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36990

Registration District No. 735 | Primary Registration District No. 3034 | Registrar's No. 193

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly 30 NOV 14 1939
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 601 Cleveland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 601 Cleveland
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Lawrence C Olds 437
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Male
5. Color or race White
6. (a) ~~Single, widowed, married~~, divorced D
6. (b) Name of husband or wife Versie Olds
6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased Aug (Month) 13th (Day) 1894 (Year)

8. AGE: Years 45 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Ky (State or foreign country)
10. Usual occupation Shoeworker
11. Industry or business Brown Shoe Co.
FATHER
12. Name Jasper Olds
13. Birthplace ____ (City, town, or county) Ky (State or foreign country)
MOTHER
14. Maiden name Mandie Robinson
15. Birthplace ____ (City, town, or county) Ky (State or foreign country)
16. (a) Informant's own signature Versie Olds
(b) Address Moberly Mo
17. (a) B (Burial, ~~cremation, or removal~~) (b) Date thereof Sept 30th 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Moberly Mo
18. (a) Signature of funeral director Mahan and Son
(b) Address Moberly Mo
19. (a) Oct 9 - 1939 (Date received local registrar) (b) Leah Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28th year 1939 hour 3 minute 30 a.M.
21. I hereby certify that I attended the deceased from Mch 6 — 38, to Sept. 28 — 1939 that I last saw him alive on Sept. 27 — 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death awaiting report of autopsy done by	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Dr. F. C. Helwig, K.C. Mo. Sept. 28 - 1939	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ?
(b) Date of occurrence ?
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature L. E. Huber (M. D.)
Address Moberly, Mo. Date signed 10/9/39

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

50M-5-17-39
Rev. 5-17-39
1 X19511

2002

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 Frank D. Hutt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo.

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

36990
Do not use this space.

1. PLACE OF DEATH
(a) County Randolph — Registration District No. 735
(b) Township — Primary Registration District No. 3034 — Registered No.
(c) City Moberly — (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 Lourence C. Olds
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE — YEARS 45 — MONTHS 10 — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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

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

17. INFORMANT (ADDRESS)

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....
Local Registrar.

"Advanced cavitating Tuberculosis in a lung containing a considerable amount of Silica over normal".
"Chronic ulcerative, caseous pulmonary tuberculosis, bilateral, with extensive apical cavitations in both lungs; chronic adhesive pleurisy; Cloudy swelling of the liver and kidneys".

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28, 1939

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

	Date of onset
Autopsy Report	
Autopsy ~~Done by~~ Done by	
Dr. F. C. Helwig K.C.	

Other contributory causes of importance:
Sept 28 1939

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. E. Huber, M. D.
(Address) Moberly 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.

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

SUM-8-9-37 I X12241