

FILED JUN 6 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. 3015

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Bronville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 days  
In this community In Saline County always (Specify whether years, months or days)

3. (a) PRINT FULL NAME George William Oquist

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased incl 20 - 1920  
(Month) (Day) (Year)

8. AGE: Years 14 Months 10 Days 13 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Mt Leonard Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Clavinus Dean Oquist  
13. Birthplace Cooper Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Edna Francis Sallay  
15. Birthplace Benton Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Father of deceased

(b) Address Marshall Mo

17. (a) burial (b) Date thereof 5-7-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cem. Marshall Mo

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall Mo

19. (a) 5-7-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Marshall  
(If outside city or town limits, write "RURAL")  
(d) Street No. 773 - So. Salt Pond  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ✓ \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5<sup>th</sup>  
year 1940 hour 11 minute 35 P.M.

21. I hereby certify that I attended the deceased from May 3, 1940 to May 5, 1940  
that I last saw him alive on May 5, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Interstitial nephritis -  
Due to Scarlet Fever - Previously 7 MOS

Due to \_\_\_\_\_  
Other conditions Secondary Anemia  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations no operation  
Of autopsy no autopsy  
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? 107  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature M.H. Bigler (M. D. or other) MD  
Address Bronville Mo Date signed 5/5/40

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
6/27/40  
Date Filed

**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 *Felix Remy*  
Licensed Embalmer No. 4127  
P. O. Address Marshall, 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.**