

No. 2  
1-4-41  
-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28321  
Registrar's No. 671

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield

(c) Name of hospital or institution: ST. JOHN'S HOSP.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene

(c) City or town Springfield

(d) Street No. (R.F.D. #6) Hutchinson St  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME HARVEY DEWEY OLLER

3. (b) If veteran, name war NONE

3. (c) Social Security No. 491-03-1774

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife DELLA A. OLLER

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased April 20 - 1903  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>138</u>	<u>3</u>	<u>28</u>	hr. min.

9. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business American Coasting Co.

12. Name Miles Thomas Oller

13. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Baker

15. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Della A. Oller

(b) Address Rt 6, Springfield, Mo.

17. (a) Funeral (b) Date thereof Aug 24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. W. King

(b) Address Springfield, Mo.

19. (a) 8-21-41 (b) J. W. King  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18<sup>th</sup>  
year 1941 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from Aug 13<sup>th</sup>  
1941 to Aug 18, 1941

that I last saw him alive on Aug 18, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute appendicitis  
(gangrene, Perforated)

Due to \_\_\_\_\_

Due to 1-2-1-1

Other conditions (Include pregnancy within 3 months of death)

Major findings: Perforated Appendicitis  
Of operations Gangrenous appendicitis

Of autopsy \_\_\_\_\_

Duration 9 days

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

Signature Lowell Graham (M. D. or other) \_\_\_\_\_  
Address Hallam Hwy Springfield Date signed 8/19/41

9844 (Licensed Embalmer's Statement on Reverse Side)

SEP 3 1941

SEP 4 1941

AMOUNT

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed *William Max Rhodes*

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

**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, fact should be so stated above.**

111