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DEPARTMENT OF COMMERCE

RECEIVED OCT 14 1941

318

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31612

Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 725

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(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)

3. (a) PRINT FULL NAME George F. Olendorf

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mahtilda Olendorf 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased July 20, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>1</u>	<u>15</u>	_____ hr. _____ min.

9. Birthplace Middleport, New York
(City, town, or county) (State or foreign country)

10. Usual occupation Outdoor Advertising Company

11. Industry or business _____

12. Name George H. Olendorf

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

14. Maiden name Caroline Forrest

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

16. (a) Informant Mrs. George F. Olendorf

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 9/8/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 9-8-41 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

7 D T (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1207 D. Weller
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5
year 1941 hour 3 minute 05 A.M.

21. I hereby certify that I attended the deceased from Aug 23, 1941, to Sept 5, 1941;
that I last saw him alive on Sept 4, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Glomerulo Nephritis</u>	<u>1 mo</u>
<u>Arterio sclerosis.</u>	<u>10 yrs</u>
<u>Coronary Thrombosis</u>	<u>90 da</u>
<u>Myocarditis - Vascular</u>	

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

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) _____
Means of injury _____
23. Signature Francis B. Camp (M. D. or other) _____
Address Springfield, Mo Date signed Sept 5-41

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

MOTHER FATHER

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 *Wayne Hinkle*

Licensed Embalmer No. *3444*

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.