

No. 2-5-42
17-39
K32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22203

FILED JUL 8 1943
Registration District No. 2290

Primary Registration District No. 5909

State File No. _____
Registrar's No. 32

1. PLACE OF DEATH:

(a) County PLATTE

(b) City or town Rural Fairview
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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 CHARLES ADDISON OLIVER

3. (b) If veteran, name war NO

3. (c) Social Security No. None

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife VETA MURDOCK

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

7. Birth date of deceased JULY 16 1894
(Month) (Day) (Year)

8. AGE: Years 48 Months 10 Days 7

If less than one day _____ hr. _____ min.

9. Birthplace WESTON MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name ADAM OLIVER

{ 13. Birthplace MICH. MISSOURI
(City, town, or county) (State or foreign country)

{ 14. Maiden name MAMIE BANNING

{ 15. Birthplace FARLEY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alberta Blankenship

(b) Address 105 E 34th R.E. Mo.

17. (a) Burial (b) Date thereof May 25, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Graceland Ave.

18. (a) Signature of funeral director W. R. Vaughn

(b) Address Weston Mo.

19. (a) 6-2-43 (b) Mrs. Clay Giffey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte

(c) City or town Rural 83
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1943 hour 81 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 14, 1943
_____ 19____ to May 16 1943
that I last saw him alive on May 18 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis 1 yr
Duration

Due to _____

Due to _____

Other conditions Metastasis to liver
(Includes pregnancy within 3 months of death)

Major findings: H6
Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature Edward J. Lewis (M. D. or other) M.D.
Address Platte City, Mo. Date signed 7/24/43

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

RECEIVED

District Health Officer No. Platt

District File Number 7-43-69

Date Filed 7-6-43

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 W. R. Vaughn
Licensed Embalmer No. 04023
P. O. Address Weston, 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, fact should be so stated above.

Registration District No. 280 Primary Registration District No. (5959)

1. PLACE OF DEATH:
(a) County Platte
(b) City or town Platte City - Rural Fair Sup.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Charles A. Oliver
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 w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 16 1918
(Month) (Day) (Year)

8. AGE: Years 48 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Miss Clay Liffie
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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

S-22203