

No. 2
M-5-43
y. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2021

FILED JAN 24 1945
Registration District No. 301

Primary Registration District No. 4450

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

91
10

1. PLACE OF DEATH:

(a) County Ripley

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

(c) Name of hospital or institution: WILLIAMS 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 36 years
years, months or days

3. (a) PRINT FULL NAME Charles Crane Ollar

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, WIDOWED

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 3-10-1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 9
If less than one day _____ hr. _____ min.

9. Birthplace Minnesota Mo. N
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name John W. Ollar

13. Birthplace Ny 1
(City, town, or county) (State or foreign country)

14. Maiden name Page

15. Birthplace Ky 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles Brooks

(b) Address St. Louis Mo.

17. (a) Burial (b) Date thereof 12-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bennett, Mo.

18. (a) Signature of funeral director J. S. Jordan

(b) Address Doniphan, Mo.

19. (a) 12/24/45 (b) E. D. Johnston
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Ripley 91

(c) City or town NEAR BENNETT
(If outside city or town limits, write "RURAL")

(d) Street No. RURAL
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country NATIVE U.S.A. 11

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
year 1944 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from November 8 1944 to Dec. 19 1944
that I last saw him alive on Dec. 19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Bowel obstruction

Due to Cancer of ascending colon

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: 462

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 J. Williams (M. D. or other) _____
Address DONIPHAN, MO. Date signed 12-20-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

674

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. *32001*

P. O. Address *Doniphan*

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.

Mo.