V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8741

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1134

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

8
3
8

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mrercy Hospital enroute 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community none
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54
(c) City or town Lexington 3
(If outside city or town limits, write "RURAL")
(d) Street No. Nth 17th 2
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BONNIE JOE OLIPHANT

3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Female /
5. Color or race White
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 Mar. (Month) 10 (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day 4 hr. 30 min.

9. Birthplace Lexington (City, town, or county) Missouri (State or foreign country)
10. Usual occupation None
11. Industry or business

FATHER
12. Name James R. Oliphant
13. Birthplace Richmond (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Bonnie Joe Eapman
15. Birthplace Lexington (City, town, or county) Mo. (State or foreign country)

16. (a) Informant James R. Oliphant
(b) Address Lexington, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar. (Month) 10 (Day) 1945 (Year)
(c) Place: burial or cremation Lexington, Mo.
18. (a) Signature of funeral director Tempel Fun. Home
(b) Address Lexington, Mo
19. (a) 3-10-45 (Date received local registrar) (b) T. E. Brown (NZ) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 10
year 1945 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-10, 1945 to 3-10, 1945
that I last saw her alive on 3-10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death ~~[illegible]~~ 8
Intestinal obstruction
Due to n. m. o.
Due to
Other conditions 157 8'
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature G. W. Fredendall (M. D. or other)
Address Lexington Mo. Date signed

(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 .....

..... Registered Apprentice No. .....,

working under my personal supervision.

Not Embalmed

Signed Geo. McKeen

Licensed Embalmer No. 2983

P. O. Address Lexington 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.