

FILED JUL 9 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 6225

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Wernon  
(b) City or town Beulah - Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp # 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 months  
In this community same  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Robert Oblinger  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 499-16-9403

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, Widowed  
(b) Name of husband or wife Clara Amanda Oblinger (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Jan 11 1888  
(Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 27  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Shipping Clerk

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Barrett Clark Oblinger  
13. Birthplace Lewisburg Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Mollie Freeman  
15. Birthplace Moberly Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Beap Reed

(b) Address Merfada Mo

17. (a) Removal (b) Date thereof 6-7-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kennett City, Mo

18. (a) Signature of funeral director Thom E. Quirk

(b) Address Kansas City Mo

19. (a) 6-7-45 (b) J. Coyne Beurck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Merfada  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4401 Garfield  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7  
year 1945 hour 9 minute 35 P.M.

21. I hereby certify that I attended the deceased from Feb. 7 1945 to June 7 1945  
that I last saw him alive on June 7 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Cerebral apoplexy  
Due to Meningeal effusion

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

Major findings: \_\_\_\_\_  
Of operations (S)  
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 Wm J. Cooney (M. D. or other)  
Address Merfada Date signed 6/7/45

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

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

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FILED

RECEIVED

District Health Officer No. 71

District File Number 6-45-604

Date Filed 7-7-45

JUL 17 1945 JUL 23 1945

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 *Thomas E. Zwick*  
Licensed Embalmer No. 3775  
P. O. Address K.C. 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.