No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Order Certified Copy

State File No. 28178

Registration District No. 276
Primary Registration District No. 5947
Registrar's No.

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

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town St. James Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Federal Soldiers Home 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 4 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Johnson 51
(c) City or town Holden Mo. 1 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Oscar O. Oliphant
3. (b) If veteran, name war No 1.
3. (c) Social Security No. 500-10-7446
4. Sex M 0
5. Color or race Wh
6. (a) Single, widowed, married, divorced 3
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 20 1880 (Month) (Day) (Year)
8. AGE: Years 65 Months 6 Days 27 If less than one day hr. min.
9. Birthplace Warrensburg (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Dont Know
11. Industry or business "
FATHER
12. Name " "
13. Birthplace " (City, town, or county) " 9 (State or foreign country)
MOTHER
14. Maiden name " "
15. Birthplace (City, town, or county) 9 (State or foreign country)
16. (a) Informant Hospital Records.
(b) Address
17. (a) Miller Co Mo (Burial, cremation, or removal) (b) Date thereof 6-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Brumley Mo
18. (a) Signature of funeral director W E Kichlider
(b) Address St James Mo
19. (a) 8-18-1945 (Date received local registrar) (b) D Claude Dickson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1945 hour 6 minute 30 P.M.
21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...;
that I last saw him dead on Aug 18 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Obstruction — Duration
Due to Chronic Myocarditis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
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? (Specify type of place)
While at work? (e) Means of injury 3

23. Signature D Claude Dickson Coroner (M.D. or other)
Address Rolla Mo Date signed 8/18/45

1447

(Licensed Embalmer's Statement on Reverse Side)

SEP 12 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 W. E. Lockhart Jr

Licensed Embalmer No. 1970

P. O. Address St James 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.

. No. 2B
M—3-45
I X43880

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

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 276 Primary Registration District No. 5947 Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town St Johnes Twp. (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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Oscar O. Oliphant

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 divorced

6. (b) Name of husband or wife —

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

7. Birth date of deceased Jan (Month) 20 (Day) 1880 (Year)

8. AGE: Years 65 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Cora E. Birmingham (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec (Day) year 1945 hour 7 minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

1945

S-28178