

S. No. 2
OM-5-43
Rev. 5-17-39
I X 3667

FILED DEC 29 1945
Registration District No. **209**

Primary Registration District No. **3043**

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: St. Elizabeth's Hospital **0**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion **64**

(c) City or town Hannibal **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 1323 Mark Twain Ave **4**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME Ora Lee Oldman

3. (b) If veteran, name war _____

3. (c) Social Security No. 490-07-9067

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14
year 1945 hour _____ minute 12²⁹ A.M.

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased: October 23 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10/20 1945, to 11/4/45, 19____
and that death occurred on the date and hour stated above.
that I last saw him alive on 11/3 1945

8. AGE:

Years	Months	Days	If less than one day
<u>37</u>	<u>1</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death: Pulmonary Congestion **24 Day**

Due to: Auricular Fibrillation **26 Days**

Due to _____

9. Birthplace: Hannibal, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Western Union Operator

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

MOTHER FATHER

11. Industry or business _____

12. Name Tommy Oldman

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

14. Maiden name Minnie Radtke

15. Birthplace La Cross, Wis
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____

Of autopsy 950

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

16. (a) Informant Mary Oldman

(b) Address Hannibal, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11 16 45
(Month) (Day) (Year)

(c) Place: burial or cremation Grand View Burial Park

18. (a) Signature of funeral director J. E. O'Donnell

(b) Address Hannibal, Missouri

19. (a) 11-23-45 (Date received local registrar) (b) J. E. M. Lucke (Registrar's signature)

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. E. O'Donnell (M. D. or other) MD
Address 115 N 25 Hannibal MO Date signed 11/20/45

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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.....

H.M. O'Connell

Licensed Embalmer No. 3889

P. O. Address.....

Stamford, Missouri

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.