

No. 2  
10-25  
1733  
K47370

FILED DEC 20 1948

State File No. \_\_\_\_\_

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

Primary Registration District No. 5299

Registrar's No. 50

1. PLACE OF DEATH:

(a) County CLINTON

(b) City or town LATHROP  
(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)

In this community 20 yr. (years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County clinton <sup>25</sup>

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PEARL EDWARD OLDHAM

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 500-07-2590

4. Sex MALE 5. Color or race White

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

6. (c) Age of husband or wife 3 years

7. Birth date of deceased 12 3 1885  
(Month) (Day) (Year)

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

63 0 5 hr. \_\_\_\_\_ min.

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

10. Usual occupation FARMER

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

MOTHER, FATHER

12. Name ALFRED WASHINGTON OLDHAM

13. Birthplace CEGAR MO  
(City, town, or county) (State or foreign country)

14. Maiden name AMERICA JANE FIRESTONE

15. Birthplace CEGAR MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Carl Stant

(b) Address Lathrop Mo

17. (a) Burial (b) Date thereof 12-9-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STOCKTON MO

18. (a) Signature of funeral director De MOSS CRUNK

(b) Address CAMERON MO

19. (a) 12-8-48 (b) Wimfred W. Moser  
(Date received local registrar) (Registrar's signature) 240

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7  
year 1948 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 7-19-  
1948 to 12-7 1948;

that I last saw him... alive on 12-7 1948;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Pulmonary Edema

Due to Carcinoma of Rt. Lung  
By Biopsy

Due to \_\_\_\_\_

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy HP

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 6

23. Signature J. A. Santner (M. D. or other)

Address Lathrop, MO Date signed 12-7-48

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

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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 *Harold L. Walker*

Licensed Embalmer No. *4588*

P. O. Address *Lathrop 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *Jan*Registration District No. *75*Primary Registration District No. *299*Registrar's No. *50*

## 1. PLACE OF DEATH:

- (a) County *Clinton*  
 (b) City or town *Lathrop*  
 (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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days3. (a) PRINT  
FULL NAME *Pearl C. Oldham*

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
- OMA OLDHAM*
- 
6. (c) Age of husband or wife if
- 
- alive
- 64*
- years

7. Birth date of deceased
- Dec 2*
- 
- (Month) (Day) (Year)

8. AGE:
- 63*
- Years Months Days
- 
- If less than one day
- 
- hr. min.

9. Birthplace
- MO*
- 
- (City, town, or county) (State or foreign country)

## 10. Usual occupation

## 11. Industry or business

12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_
- 
- (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)
- 
- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_
- 
- (b) Address \_\_\_\_\_

19. (a)
- 12-8-48*
- (b)
- Winifred W. Moser*
- 
- (Date received local registrar) (Registrar's signature)

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_
- 
- year
- 1948*
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_
- 
- to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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 sta-  
tistically.

## 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

S-39662