

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16888
2243

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 30 yrs.		d. STREET ADDRESS (If rural, give location) 709 W. 43rd. Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) C. c. (Last) Oelfke			4. DATE OF DEATH (Month) (Day) (Year) May 16, 1950		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 16, 1869	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs. Mary C. Oelfke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruby E. Oelfke, 709 W. 43rd. Street	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days 11 days 7 years 332X
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Thrombosis		
	DUE TO (c) Arterio sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-6**, 19**50**, to **5-16**, 19**50**, that I last saw the deceased alive on **5-16**, 19**50**, and that death occurred at **5:20 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Hubert M. Parker (Degree or title) Hubert M. Parker, M.D.		23b. ADDRESS 520 Argyle	23c. DATE SIGNED 5-17-50
24a. BURIAL, CREMATION, REMOVAL (Specify) removal 5	24b. DATE 5-19-50	24c. NAME OF CEMETERY OR CREMATORY Garnavillo, Iowa	

DATE REC'D BY LOCAL REG. 5-17-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary, Kansas City, Missouri
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(Licensed Embalmer's Statement on Reverse Side)

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

1130-5-0

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Oliver C. Wedelin

Licensed Embalmer No. 3493

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.