

FILED JUN 19 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20818**
 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **383** PRIMARY REG. DIST. NO. **5655** Registrar's No. **296**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Lawrence</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>Lawrence</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Van M. Yannon MO 3 1/2 yrs</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sarcoxie MO 0550</b>                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Regby Rest Home</b>   |  | d. STREET ADDRESS (If rural, give location) <b>With in Lawrence</b>   |  |

|   |   |
|---|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Eda</b> b. (Middle) <b>Estelle</b> c. (Last) <b>Oliver</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>June 12 1950</b> |
|---|---|

|                  |                               |   |                                   |   |   |   |
|------------------|-------------------------------|---|-----------------------------------|---|---|---|
| 5. SEX <b>FM</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>3/16/1869</b> | 9. AGE (If years last birthday) <b>81</b> | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>26</b> | IF UNDER 4 HRS.<br>Hours <b></b> Min. <b></b> |
|------------------|-------------------------------|---|-----------------------------------|---|---|---|

|  |   |   |   |
|--|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>housekeeping</b> | 11. BIRTHPLACE (State or foreign country) <b>near Co. near State Tenn USA</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
|--|---|---|---|

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME <b>Thomas Rooten</b> | 13b. MOTHER'S MARDEN NAME <b>Mary Josephine Mathia Charles Oliver</b> | 14. NAME OF HUSBAND OR WIFE <b>Francis L. Oliver Sarcoxie</b> |
|---|---|---|

|   |                                   |   |                         |
|---|-----------------------------------|---|-------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> | 16. SOCIAL SECURITY NO. <b>No</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Francis L. Oliver Sarcoxie</b> | ADDRESS <b>Sarcoxie</b> |
|---|-----------------------------------|---|-------------------------|

|   |   |             |                                  |
|---|---|-------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |             | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Toxemia from abscess of</b>   |             | <b>2 weeks</b>                   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Defective circulation in foot &amp; leg.</b> |             | <b>2 months</b>                  |
| DUE TO (c) <b>Pneumonia</b>   |   | <b>455A</b> | <b>6 weeks</b>                   |
| II. OTHER SIGNIFICANT CONDITIONS<br>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 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) m. | 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 **April 10, 1950**, to **June 12, 1950**, that I last saw the deceased alive on **June 11, 1950**, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|   |                                   |                                       |
|---|-----------------------------------|---------------------------------------|
| 23a. SIGNATURE (Degree or title) <b>D. A. Johnson, M.D.</b> | 23b. ADDRESS <b>Mt Vernon, Mo</b> | 23c. DATE SIGNED <b>June 13, 1950</b> |
|---|-----------------------------------|---------------------------------------|

|   |                          |   |   |
|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> | 24b. DATE <b>6/14/50</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Goss Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Near Phelps MO</b> |
|---|--------------------------|---|---|

|   |   |     |   |                              |
|---|---|-----|---|------------------------------|
| DATE REC'D BY LOCAL REG. <b>June 14, 1950</b> | REGISTRAR'S SIGNATURE <b>Leil Hendricks</b> | 411 | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. B. Orr</b> | ADDRESS <b>Mt Vernon, Mo</b> |
|---|---|-----|---|------------------------------|

(Licensed Embalmer's Signature on Reverse Side)

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

No. 300  
10.48

550

4

JUN 15 1950  
District Health Office No. 6,  
District File Number 650-668  
Date Filed 6/15/50

**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 \_\_\_\_\_

*George B. Orr*

Licensed Embalmer No. 946

P. O. Address W. Vernon

**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.