

27524

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 23 1950

BIRTH NO. _____ REG. DIST. NO. 207 PRIMARY REG. DIST. NO. 5757 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Maries</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Johnson Leap</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Safe, Missouri</u>	
c. LENGTH OF STAY (in this place) <u>31 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>none</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Frederick</u> c. (Last) <u>Oberkrom</u>			4. DATE OF DEATH: (Month) <u>8</u> (Day) <u>13</u> (Year) <u>50</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>9-12-1864</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR <u>11</u> Months <u>1</u> Days	IF UNDER 24 HRS. <u>1</u> Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Gasconade County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Wm. F. Oberkrom</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Meyers</u>		14. NAME OF HUSBAND OR WIFE <u>Maria Oberkrom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Anna Smallwood Bland, Mo.</u>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 weeks</u> <u>4 1/2</u> <u>6 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Influenza</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Anemia (perisisms) about</u>			

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) _____		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 July 30, 1950, to August 13, 1950, that I last saw the deceased alive on August 12, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. H. Ammler, M.D.</u> (Degree or title)		23b. ADDRESS <u>St. James, Mo.</u>		23c. DATE SIGNED <u>8-14-50</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-15-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>	
		24d. LOCATION (City, town, or county) <u>St. James, Mo.</u>		(State) _____	

DATE REC'D BY LOCAL REG. <u>8-18-50</u>		REGISTRAR'S SIGNATURE <u>Pauline Howard</u> <u>188</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. Jesse Gahr St. James, Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48
1130

File No. _____
DISTRICT HEALTH OFFICE No. 4

AUG 19 1950

RECEIVED

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.

Signed _____

C. Jesse Gahr

Signed _____
Student Embalmer

Licensed Embalmer No. *4486*

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.