

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Johnson 13505
State File No. 13505

FILED MAY 5 - 1952

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 163

582
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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| 1. PLACE OF DEATH a. COUNTY <u>Binn</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Chariton</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Birmingham Towns</u> | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) <u>0210</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Barney Hospital</u> | | | |

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|--|---------------------------|---------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>WILLIAM</u> | b. (Middle) <u>ALFRED</u> | c. (Last) <u>OLINGER</u> | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | <u>Apr - 27 - 1952</u> |

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|------------------|---------------------------|---|--|---|---|--|
| 5. SEX <u>Mo</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Apr - 1 - 1908</u> | 9. AGE (In years last birthday) <u>44</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>26</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
|------------------|---------------------------|---|--|---|---|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Chariton Co Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
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|---------------------------------------|---|---|
| 13a. FATHER'S NAME <u>Wm. Olinger</u> | 13b. MOTHER'S MAIDEN NAME <u>Mae Holt</u> | 14. NAME OF HUSBAND OR WIFE <u>Letha M. Olinger</u> |
|---------------------------------------|---|---|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Letha M. Olinger</u> | ADDRESS <u>Brookfield Mo</u> |
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| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | 19. INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute coronary artery disease</u> | | |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>4201</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
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| | | |
|---|--|----------------------------|
| 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 Oct. 19, 1947, to April 27, 1952, that I last saw the deceased alive on April 27, 1952, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

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|--|-------------------|--|---------------------------------|
| 23a. SIGNATURE <u>R. W. Johnson M.D.</u> | (Degree or title) | 23b. ADDRESS <u>2111 Bin Brookfield Mo</u> | 23c. DATE SIGNED <u>4/28/52</u> |
|--|-------------------|--|---------------------------------|

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|---|--------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>4/29-52</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem</u> | 24d. LOCATION (City, town, or county) (State) <u>Brookfield Mo</u> |
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|---|--|----------|---|------------------------------|
| DATE REC'D BY LOCAL REG. <u>4-30-52</u> | REGISTRAR'S SIGNATURE <u>Madine Stambach</u> | 167 Dep. | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Blacklock</u> | ADDRESS <u>Brookfield Mo</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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 J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield 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.