

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8659

State File No.

FILED APR 14 1953

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4014 Registrar's No. 33

4030
0

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>Atchison</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u> | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <u>airfax</u> | | c. LENGTH OF STAY (in this place) <u>6 WKS.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>airfax Com. Hosp.</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural. Polk. Twsp. 0030</u> | |
| | | d. STREET ADDRESS (If rural, give location) <u>none</u> | |

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|--|---------------------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> | b. (Middle) <u>Thomas</u> | c. (Last) <u>Oslin</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>4-5-1953</u> |
|--|---------------------------|------------------------|--|

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|--------------------|-------------------------------|--|-----------------------------------|---|---|---------------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>4-19-1885</u> | 9. AGE (In years last birthday) <u>67</u> | 10. UNDER 1 YEAR (Months) (Days) <u>11 16</u> | 11. UNDER 1 MRS. (Hours) (Min.) |
|--------------------|-------------------------------|--|-----------------------------------|---|---|---------------------------------|

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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 <u>Agriculture</u> | 11. BIRTHPLACE (State or foreign country) <u>Linden, Mo.,</u> | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> |
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|--|---|---|
| 13a. FATHER'S NAME <u>Samuel Oslin</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Dailey</u> | 14. NAME OF HUSBAND OR WIFE <u>none</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>Ray Oslin, Watson. Mo.,</u> | ADDRESS |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Lobar Pneumonia</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Cardiac Decompensation 6 yrs</u> DUE TO (c) <u>Generalized Arterio-sclerosis</u> | | |
| 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 | 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) | 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 3-15, 1953, to 4-5, 1953, that I last saw the deceased alive on 4-5, 1953, and that death occurred at 11 P. m., from the causes and on the date stated above.

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|---|---------------------------------|--------------------------------|
| 23a. SIGNATURE <u>Wallace Carpenter</u> (Degree or title) | 23b. ADDRESS <u>Rockport Mo</u> | 23c. DATE SIGNED <u>4-6-53</u> |
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|---|---------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>4/7/1953</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Linden, Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Rock P rt. Mo.,</u> |
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| DATE REC'D BY LOCAL REG. <u>4/8/1953</u> | REGISTRAR'S SIGNATURE <u>Maxwell N. Schaefer (you)</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Bartholomew Mortuary, Rockport. Mo</u> | ADDRESS |
|--|--|--|---------|

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.....

Grat Benthall

Signed.....

Student Embalmer

Licensed Embalmer No. 3173

P. O. Address Rock Port. 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.