No. 300
10.48

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

FILED OCT 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36340

State File No. .....

BIRTH NO. ..... REG. DIST. NO. 375 PRIMARY REG. DIST. NO. 6283 Registrar's No. 26

1. PLACE OF DEATH
a. COUNTY: WRIGHT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ELK CREEK RURAL
c. LENGTH OF STAY (in this place): 15 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO.
b. COUNTY: WRIGHT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ELK CREEK (RURAL)
d. STREET ADDRESS (If rural, give location): 1140

3. NAME OF DECEASED (Type or Print)
a. (First): SARAH
b. (Middle): ANN
c. (Last): OLIPHANT

4. DATE OF DEATH (Month) (Day) (Year): 9 24 54

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: SEPT. 26, 1874
9. AGE (In years last birthday): 79
If under 1 year: Months 11 Days 29
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (City and State or Foreign Country): ARKANSAS
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: FATE AUSTIN
13b. MOTHER'S MAIDEN NAME: ✓
14. NAME OF HUSBAND OR WIFE: RILEY OLIPHANT (DEC)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: O. M. Cope
ADDRESS: Hartville, Mo.

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senile Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: ✓

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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: 493X
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-15, 1954, *to* 9-24, 1954, *that I last saw the deceased alive on* 9-24, 1954, *and that death occurred at* 11:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] M.D.
23b. ADDRESS: Grove Springs
23c. DATE SIGNED: 10-7-54

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 9-27-54
24c. NAME OF CEMETERY OR CREMATORY: GREEN MTN.
24d. LOCATION (City, town, or county) (State): N. MT. GROVE MO

DATE REC'D BY LOCAL REG.: 10-8-54
REGISTRAR'S SIGNATURE: B. Garner 3460
25. FUNERAL DIRECTOR'S SIGNATURE: John S. Simpson
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED OCT 19 1954
WRIGHT CO. HEALTH DEP.
County File Number 1054-104
Date Filed 10-16-54

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 R. H. Barber

Licensed Embalmer No. 3848

P. O. Address _____

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.