

FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 20289
Registrar's No. 5024

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1 year		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3901 Carter Avenue				e. STREET ADDRESS (If rural, give location) 3901 Carter Avenue 2090			
3. NAME OF DECEASED (Type or Print) a. (First) Harry		b. (Middle) Wilson		c. (Last) Oatman		4. DATE OF DEATH (Month) (Day) (Year) June 7 1955	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH August 3, 1866	
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardmaster (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Terminal R.R. Ass'n		11. BIRTHPLACE (City and State or Foreign Country) Fort Madison, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles Oatman		13b. MOTHER'S MAIDEN NAME Wilson		14. NAME OF HUSBAND OR WIFE Belle C. Oatman (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Lester Oatman, 3901 Carter Avenue			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Hypertrophy DUE TO (c) Mitral Stenosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 24 hours ? ?	
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? 410X			
22. I hereby certify that I attended the deceased from June 6, 1955 , to June 7, 1955 , that I last saw the deceased alive on June 7, 1955 , and that death occurred at 7 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Robert C. McEwain, M.D.				23b. ADDRESS 4356 Warne Avenue (7)		23c. DATE SIGNED 6-9-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal via rail		24b. DATE June 10, 1955		24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		24d. LOCATION (City, town, or county) (State) Fort Madison, Iowa	
DATE REC'D BY LOCAL REG. JUN 9 1955		REGISTRAR'S SIGNATURE Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Ave			

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed.....
2737
Licensed Embalmer No.....
St. Louis, Mo. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.