

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33003

State File No.

BIRTH NO. _____ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 4225 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY <u>HOLT</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 town)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township)					
OR TOWN <u>OREGON</u>				OR TOWN <u>RURAL (CLAY TWP)</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS (If rural, give location) <u>NONE</u>					
3. NAME OF DECEASED (Type or Print)			a. (First) <u>MARTINA</u>	b. (Middle)	c. (Last) <u>OSWALD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10-16-1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>11-21-1861</u>			
9. AGE (In years last birthday) <u>93</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		9. AGE (In years last birthday) <u>93</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>ALBERT OSWALD (DEC)</u>			
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 ADDRESS <u>Paul Oswald, Rock Port, 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>				DUE TO (b) <u>Cerebrovascular Accident</u>				<u>3 days</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) <u>Arteriosclerosis 331x</u>				<u>3 months</u>	
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						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) m.		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 <u>Sept 1</u> , 19 <u>55</u> , to <u>Oct 16</u> , 19 <u>55</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>James F. Sweeney M.D.</u>				23b. ADDRESS <u>Oregon, Missouri</u>				23c. DATE SIGNED <u>10-19-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10-19-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LINDEN CEM</u>		24d. LOCATION (City, town, or county) (State) <u>Rock Port, Mo</u>			
DATE REC'D BY LOCAL REG. <u>10-18-1955</u>		REGISTRAR'S SIGNATURE <u>James Crawford</u>		401		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BARTHELEMEW MORTUARY Rock Port Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

18-110

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 Geoff Bechtman

Licensed Embalmer No. 3173

P. O. Address Rox. Post. ms

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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