

FILED DEC 19 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41018**

BIRTH NO. _____ REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 2018 Registrar's No. 85

1. PLACE OF DEATH a. COUNTY <u>DENT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SHANNON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SALEM</u>	c. LENGTH OF STAY (In this place) <u>7 MONTHS</u>	c. CITY OR TOWN <u>EMINENCE</u>	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 <u>KNOX NURSING HOME</u>		e. STREET ADDRESS (If rural, give location) <u>1010</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>GERTRUDE</u>	b. (Middle)	c. (Last) <u>OLIVER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 8 1956</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>JUNE 16, 1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>COLUMBIA, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>BURL HAZARD</u>	13b. MOTHER'S MAIDEN NAME <u>NANCY O'HEARN</u>	14. NAME OF HUSBAND OR WIFE <u>FRANCIS N. OLIVER (DECD)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>KNOX NURSING HOME</u>	ADDRESS <u>SALEM, MO.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerosis and Rheumatic Heart disease with valvular defect.</u>		
	DUE TO (c) <u>Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

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) <u>332X</u>
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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?
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22. I hereby certify that I attended the deceased from 1955, 1955, to Dec. 8, 1956, 1956, that I last saw the deceased alive on Dec. 8, 1956, and that death occurred at 7:30 AM., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>Dr.</u>	23b. ADDRESS <u>Salem Mo</u>	23c. DATE SIGNED <u>12/10/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>DEC. 10, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CEDAR GROVE CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>SALEM MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>12-10-56</u>	REGISTRAR'S SIGNATURE <u>A. E. Mitchell, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Max L Warfel</u>	ADDRESS <u>Salem, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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DEC 28 1928

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 Max R Waigel

Licensed Embalmer No. 4170

P. O. Address Salem, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.