

Health,
& Welfare
S. Public
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v. 1-57 D

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40526

STATE FILE NUMBER
5355

FILED DEC 2 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MILLER		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SUNRISE BEACH		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE RESEARCH HOSPITAL		Length of stay in 1b 4 days	d. STREET ADDRESS (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last S MITCHELL OLDHAM, Sr.			4. DATE OF DEATH NOV. 11 - 1957 Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 7 - 1887	9. AGE (In years birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGEMENT TRAINER		10b. KIND OF BUSINESS OR INDUSTRY MILGRAM FOOD STORES	11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William D. OLDHAM		13b. MOTHER'S MAIDEN NAME ETHEL MITCHELL		14. NAME OF HUSBAND OR WIFE MARTHA E. OLDHAM	
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. 486-07-4098	17. INFORMANT Address WILLIAM B. OLDHAM III 4318 WEST TRUMAN ROAD INDEPENDENCE, MISSOURI		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Rupture of cerebral blood vessels. DUE TO (c) arteriosclerosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) High Blood pressure					INTERVAL BETWEEN ONSET AND DEATH 33 1/2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18): None			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from several years to 11-11-57 and last saw him alive on 11-11-57 Death occurred at 3:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE DeLoon A. Williams (Degree or title) M.D.			22b. ADDRESS 806 Proj Bldg.		22c. DATE SIGNED 11/12/57
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV. 13, 1957	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEM.		23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		ADDRESS 1331 BROOK CREEK K.C. MO.	25. DATE RECD. BY LOCAL REG. 11-13-57	26. REGISTRAR'S SIGNATURE Irene Minshall	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
DeLoon A. Williams

