

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014705
STATE FILE NUMBER

FILED APR 23 1958

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 78

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webb City, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webb City, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>315 W. 3rd</u>		Length of stay in lb <u>4 yrs</u>	d. STREET ADDRESS <u>315 W. 3rd ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>R.</u> Last <u>Oswalt</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1882</u>	9. AGE (In years last birthday) <u>76</u>	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Nashville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Frank Oswalt</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Myers</u>		14. NAME OF HUSBAND OR WIFE	
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>494-18-2686</u>	17. INFORMANT Address <u>Miss LaVone Tandy Webb City, mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					<u>?</u>
DUE TO (c) _____					<u>4201</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)		
20c. TIME OF INJURY. Hour _____ a.m. _____ p.m. Month, Day, Year _____					
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 <u>4-12-58</u> to <u>4-19-58</u> and last saw ^{her} alive on <u>4-19-58</u> Death occurred at <u>2:30 P.M.</u> on <u>4-19-58</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or title) <u>Mrs. Madeline Switzer</u>			22b. ADDRESS <u>Webb City Mo</u>		22c. DATE SIGNED <u>4/19/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-21-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NASHVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (Specify) <u>NASHVILLE Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Johnston-Arnce-Simpson Mortuary</u> <u>Webb City, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>4-19-58</u>	26. REGISTRAR'S SIGNATURE <u>Miss Madeline Switzer</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

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 Harvey E. Orme

Licensed Embalmer No. 4463
P. O. Address West City

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.