

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017168

STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 65

300
-57

1. PLACE OF DEATH a. COUNTY <i>Cooper</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cooper</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Boonville</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Boonville</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph Hospital 10 Days</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>313 Morgan St</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Opal</i> Middle <i>Oswald</i> Last <i>Prewitt</i>			4. DATE OF DEATH Month <i>May</i> Day <i>11</i> Year <i>1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 28, 1904</i>	9. AGE (In years last birthday) <i>54</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11. BIRTHPLACE (City and state or country) <i>Cooper County, Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13a. FATHER'S NAME <i>John H. Oswald</i>		13b. MOTHER'S MAIDEN NAME <i>Frances Kee Hostler</i>		14. NAME OF HUSBAND OR WIFE <i>-----</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>495-36-6376</i>	17. INFORMANT Address <i>Mrs. Andy Anderson, Boonville, Mo.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Pulmonary Infections</i>					INTERVAL BETWEEN ONSET AND DEATH <i>5-7 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Thromboses, Pulvic Veins</i>					
DUE TO (c) <i>Following Pelvic Operation</i>					<i>12 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Marked Hives, Anaphylactic reaction Severe</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <i>9:02</i> Month <i>April</i> Day <i>30</i> Year <i>1959</i> a.m. <i>9:02</i> p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <i>April 30/1959</i> to <i>May 11/1959</i> and last saw her alive on <i>May 11/1959</i> Death occurred at <i>9:02</i> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>E. T. Humphreys MD</i>			22b. ADDRESS <i>Boonville, Mo</i>		22c. DATE SIGNED <i>May 12/1959</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 13, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Masonic Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Bunceton, Mo.</i>	
24. FUNERAL DIRECTOR <i>Goodman & Boller, Boonville, Mo.</i>		ADDRESS	25. DATE RECD. BY LOCAL REG. <i>5/13/59</i>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification: 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 William W. Wood.....

Licensed Embalmer No. 4539.....
P. O. Address Boonville, 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.