

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Dr. Park **FILED VS SEP 21 1959**

59-032035

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 971

1. PLACE OF DEATH a. COUNTY GREENE b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD Length of stay in 1b 2 WKS. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BERRY c. CITY OR TOWN CASSVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 101 E. 11th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE STEVENSON OLDAKER				4. DATE OF DEATH Month Day Year SEPT. 15 1959									
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/3/93		9. AGE (last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done or last kind if retired) RETIRED SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (City and state or country) AURORA, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME UNKNOWN				13b. MOTHER'S MAIDEN NAME HATTIE STEVENSON				14. NAME OF HUSBAND OR WIFE MYRTLE OLDAKER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) YES W.W. # 1				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MYRTLE OLDAKER CASSVILLE, MO.							
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>Bacterial Disease</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Atypical Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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.) <u>none</u>									
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year													
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 <u>9-14-59</u> , to <u>9-15-59</u> and last saw ^{her} him alive on <u>9-15-59</u> Death occurred at <u>9:10 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>W. D. ... M.D.</u>						22b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>			22c. DATE SIGNED <u>9/16/59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <u>9/21/59</u>		23c. NAME OF CEMETERY OR CREMATORY NATIONAL				23d. LOCATION (City, town or county) (State) SPRINGFIELD, MO.					
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER SPRINGFIELD, MO.						25. DATE RECD. BY LOCAL REG. <u>9-17-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie E. Meeton</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 24 1958

SEP 24 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. Hunt

Licensed Embalmer No. 4739

P. O. Address Sppl. M

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.