

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035872

Dr. Sneed

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1215

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BERRY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD			Length of stay in 1b	c. CITY OR TOWN CASSVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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"/>	d. STREET ADDRESS (If outside, give location) 101 E. ELEVEN			
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE CECELIA OLDAKER				4. DATE OF DEATH Month Day Year NOV. 10 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/13/1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) CHICAGO, ILL.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME LANS JOHNSON			13b. MOTHER'S MAIDEN NAME HILMA CARLSON		14. NAME OF HUSBAND OR WIFE CLARENCE OLDAKER (DEC.)		
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. NO	17. INFORMANT Address MRS. ANNA REED, CASSVILLE, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Metastatic Carcinoma							2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) carcinoma of the right breast							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pathological fracture, subtrochanteric region, right hip						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)				
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 31 August 1959 to 10 November 59 and last saw her/him alive on 10 November 1959 Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>William A. Sneed M.D.</i>				22b. ADDRESS Missouri 103 Professional Bldg, Springfield		22c. DATE SIGNED 11/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/13/59	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. 11-12-59		26. REGISTRAR'S SIGNATURE <i>Effie S. Mellon</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 02 10N SA

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 AL McCar

Licensed Embalmer No. 2720

P. O. Address: Springfield, 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.