

RJ DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS JUL 1 1960

=60-022248

STATE FILE NUMBER

Registration District No. 11 Primary Registration District No. 5052 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <b>BARRY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>CALIF</b> b. COUNTY <b>RIVERSIDE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ROARING RIVER TWP.</b>		Length of stay in 1b <b>1 WK.</b>	c. CITY OR TOWN <b>YUCAIPA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) <b>Harry's Court</b> HOSPITAL OR INSTITUTION <b>5 Mi. S-E Cassville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>35244 Vineyard St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>JACOB</b> Last <b>OLMSCHIED</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-92</b>	9. AGE (last birthday) <b>67</b>	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) <b>Calif.-Org. Power Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (City and state or country) <b>La Sueur, Minn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Martle Olmscheid</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW I</b>		16. SOCIAL SECURITY NO. <b>541-10-8118</b>		17. INFORMANT Address <b>Roger Olmscheid, Sioux City, Iowa</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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.)	
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 \_\_\_\_\_ to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
Death occurred at 1:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>May Newman, M.D.</b>		22b. ADDRESS <b>Cassville, Mo.</b>		22c. DATE SIGNED <b>4/23/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>6-23-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>unknown</b>	23d. LOCATION (City, town, or county) (State) <b>Sioux City, Iowa</b>	

24. FUNERAL DIRECTOR ADDRESS <b>Doyle E. Williamson, Cassville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-23-1960</b>	26. REGISTRAR'S SIGNATURE <b>Grace Williams</b>
--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 1 1960

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Doyle E. Williamson

Licensed Embalmer No. 4883

P. O. Address Essauville

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.