

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046689

OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 2035 Registrar's No. 119

FILED VS JAN 3 1961

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Dafayette</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in 1b <u>54 Yr.</u>		c. CITY OR TOWN <u>Lexington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>26th. & Main</u>			d. STREET ADDRESS (If outside, give location) <u>R.F.D. 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALFRED</u> Middle <u>EUSEBIO</u> Last <u>OLIARO</u>			4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>December 18, 1906</u>	9. AGE (last birthday) <u>54</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Store</u>		11. BIRTHPLACE (City and state or country) <u>Lexington, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>Joseph Oliaro</u>	13b. MOTHER'S MAIDEN NAME <u>Camellia Mussatto</u>		14. NAME OF HUSBAND OR WIFE <u>Hattie Leuhrs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. 2</u>			16. SOCIAL SECURITY NO. <u>323-05-4672</u>		17. INFORMANT <u>Mrs. Hattie Oliaro Lex., Mo.</u> Address	
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>Acute myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
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) <u>History of previous myocardial infarctions</u>					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 <u>12-23-60</u> to <u>12/23/60</u> and last saw him alive on <u>12-23-60</u> Death occurred at <u>11:45 P/m</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Ralph W. Walker M.D.</u>			22b. ADDRESS <u>Lexington, Mo</u>		22c. DATE SIGNED <u>12-27-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lexington, Mo</u>		
24. FUNERAL DIRECTOR <u>Vaughn-Walker Lexington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-28-60</u>		26. REGISTRAR'S SIGNATURE <u>Thomas E. ...</u>		

VS JAN 5 1961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Harold L. Wae

Licensed Embalmer No. 450

P. O. Address Lexington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.