

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004803
STATE FILE NUMBER

Registration District No. 5-9 Primary Registration District No. 4097 Registrar's No. 29

AMENDED

FILED VS FEB 20 1961

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		Length of stay in 1b	c. CITY OR TOWN <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At her home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1101 Green St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>May</u> Last <u>Oram</u>	4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/1870</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Boone County, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert C. Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Frances Hudson</u>	14. NAME OF HUSBAND OR WIFE <u>William H. Oram (deceased)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. John Osborn Archie, Mo.</u>
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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>Cerebral embolus</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arterio-sclerosis</u>	
	DUE TO (c) <u>previous cerebral thrombosis</u>	
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 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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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
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21. I attended the deceased from 1950 to 2-7-61 and last saw her alive on 2-7-61
Death occurred at 9 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edwards James MD Harrisonville Mo</u> (Degree or title)	22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>2-10-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/10/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Garden City, Mo.</u>
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24. FUNERAL DIRECTOR <u>W. H. ...</u> ADDRESS <u>Harrisonville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb-10-1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Roy Sebrer</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTead OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

FEB 21 1961

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 Robert W. Ackerson

Licensed Embalmer No. 4902

P. O. Address Hammond, Ind

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.