

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044346

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 192

AMENDED

**FILED DEC 18 1961**

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Grundy</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>HARRISON</u>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Trenton</u>  |   | Length of stay in 1b <u>1 week</u>   | c. CITY OR TOWN <u>GILMAN CITY</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>WRIGHT MEMORIAL</u>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                     |
| 3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Mable</u> Last <u>ORAM</u>   |   |  | 4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1961</u>  |
| 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>5-15-1883</u>  |
| 9. AGE (last birthday) <u>79-6-29</u>   |   | IF UNDER 1 YEAR Months   | IF UNDER 24 HR Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   | 11. BIRTHPLACE (City and state or country) <u>HARRISON, Mo</u>   |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>   |   | 13a. FATHER'S NAME <u>John Christopher</u>   |  |
| 13b. MOTHER'S MAIDEN NAME <u>MATILDA HIGGINS</u>  |   | 14. NAME OF HUSBAND OR WIFE <u>JAMES FRANK ORAM</u>  |  |
| 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 <u>Edith Griffith</u> Address <u>GILMAN CITY</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |  |  |
| 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.<br><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 _____ Month, Day, Year _____   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>12-12-61</u> to <u>12-12-61</u> and last saw her/him alive on <u>12-12-61</u><br>Death occurred at <u>6:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |  |  |
| 22a. SIGNATURE <u>Oliver F. Coffey</u> (Degree or title)  |   | 22b. ADDRESS <u>Trenton Mo</u>   | 22c. DATE SIGNED <u>Dec 15 61</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 23b. DATE <u>12-17-61</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC</u>  | 23d. LOCATION (City, town, or county) (State) <u>GILMAN CITY MO</u>  |
| 24. FUNERAL DIRECTOR <u>W B Hair</u> ADDRESS <u>Bethany Mo</u>  |   | 25. DATE RECD. BY LOCAL REG. <u>12-15-1961</u>   | 26. REGISTRAR'S SIGNATURE <u>Irene Fair</u>  |

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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 \_\_\_\_\_

Licensed Embalmer No. 3899

P. O. Address Bethany, N.J.

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.