

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-050606**  
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 188

**FILED DEC 31 1963**

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		Length of stay in lb <u>3y 6mo 22d</u>	c. CITY OR TOWN <u>Holden</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>State Hosp # 3</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>unk</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>?</u> Last <u>Olinger</u>			4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>63</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>67-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>78</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HR: Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (City and state or country) <u>Belton Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Christopher Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Hanner Axtell</u>	
14. NAME OF HUSBAND OR WIFE <u>Daniel W Olinger</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>	
16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Records</u> Address <u>State Hosp # 3 Nevada Mo</u>	
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 Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>unk</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome assoc. &amp; senility</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 <u>  </u> a.m. <u>  </u> 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 viewed the deceased from <u>remains 12-25-63 at 4:50 AM</u> and last saw him alive on <u>  </u> Death occurred at <u>12-25-63 4:20 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Nevada Mo</u>	
22c. DATE SIGNED <u>12-20-63</u>		23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>12-28-1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	
23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Floral Hills Funeral Home</u> ADDRESS <u>Kansas City Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-28-1963</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Rev. 4/59

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**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 E. M. Jordan

Licensed Embalmer No. 3453

P. O. Address K. E. Han.

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.