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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 26 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31030
Registrar's No. 209

Registration District No. 73 Primary Registration District No. 3006

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia, Mo.
(c) Name of hospital or institution: Ellis Fischel Cancer Hospital
(d) Length of stay: In hospital or institution: 45
In this community: years, months or days

3. (a) PRINT FULL NAME: William Henry Oliver
3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex: Male 5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Juanita Olive
6. (c) Age of husband or wife if alive: 55 years
7. Birth date of deceased: 3/4/1873

8. AGE: Years 08 Months 47 Days 27 If less than one day hr. min.

9. Birthplace: Sullivan Co MO (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: _____

MOTHER FATHER { 12. Name: Wm Henry Oliver Jr.
13. Birthplace: Sullivan Co MO (City, town, or county) (State or foreign country)
14. Maiden name: Susan Shepherd
15. Birthplace: Sullivan Co MO (City, town, or county) (State or foreign country)

16. (a) Informant: Hospital Records (b) Address: Columbia, Mo.

17. (a) Burial (b) Date thereof: 8-3-41 (c) Place: burial or cremation: Milan, Mo.

18. (a) Signature of funeral director: Parker's (b) Address: Columbia, Mo.

19. (a) Date received local registrar: 8/1/41 (b) Registrar's signature: Allie Selby

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Sullivan 105
(c) City or town: Milan Rural 0
(d) Street No. _____ (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 8 day 1 year 1941 hour 5 minute 40 P.M.

21. I hereby certify that I attended the deceased from 6-18-41, 19, to 8-1-41, 19, that I last saw him alive on 8-1-41, 19, and that death occurred on the date and hour stated above.

Immediate cause of death: Melano Carcinoma Duration 15 yr

Due to _____
Due to _____
Other conditions: (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy: Milan carcinoma with metastases to SK, heart, adrenals, liver, thyroid, pancreas

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: James V. Ackerman (M. D. or other) A.M.D.
Address: Ellis Fischel State Cancer Hospital Date signed 8/1/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

M. J. Philander

Licensed Embalmer No.

3893

P. O. Address

Columbus, Mo

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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31030

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Henry Olive

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3-4-1873
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 20 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11/10/41 (b) Allie Selby
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 Day 19 Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Melano Carcinoma
Primary seat was probably from a mole on skin of the chest.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 53

Of autopsy Melano Carcinoma with metastasis to skin, heart, adrenal glands

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1941
S-31030