

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

1. PLACE OF DEATH:

(a) County Hawell

(b) City or town West Plains  
(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Hawell

(c) City or town West Plains  
(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 Oliver Perry Cushman

3. (b) If veteran,  name war \_\_\_\_\_

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 13  
year 1946 hour 10 minute 10 a.m.

4. Sex MO 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Lola Cushman

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 1-24-1855  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 26 Oct, 1946, to 13 Nov, 1946, that I last saw him alive on 12 Nov, 1946, and that death occurred on the date and hour stated above.

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>91</u> | <u>9</u> | <u>19</u> | hr. _____ min.       |

Immediate cause of death: CHRONIC MYOCARDITIS  
ARTERIOSCLEROSIS  
AC. PULMONARY EDEMA

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

Due to \_\_\_\_\_

10. Usual occupation Fish Culturist

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Oliver Cushman

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

14. Maiden name unk

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

Major findings: Of operations 11/21

Of autopsy \_\_\_\_\_

16. (a) Informant Mrs. O.P. Cushman

(b) Address West Plains, Mo

17. (a) B. (b) Date thereof 11-15-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? 11

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director Robertsons

(b) Address West Plains, Mo

19. (a) Nov. 19-1946 (b) Beatrice Cook  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place)

23. Signature Robertson, M.D. (M. D. or other) M.D.

Address West Plains, Mo Date sign 12/11/46

RECEIVED

District Health Officer No. 5.

District File Number. 1246653

Date Filed 12-6-46

DEC 20 1946

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.....

S. L. Duncan, Registered Apprentice No. 390  
working under my personal supervision.

Signed A. A. Robertson

Licensed Embalmer No. 34325

P. O. Address Nest Plains,

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.