

No. 2
-5-43
-17-39
X36671

FILED OCT 29 1947

State File No. _____

Registration District No. 2

Primary Registration District No. 54774387

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Alton
(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 Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75
(c) City or town Alton 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Joie E. Ollar

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rudolph Ollar 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased January 3 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>5</u>	<u>14</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Wright Simpson

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

14. Maiden name Samantha Cates

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

16. (a) Informant Mrs. Wheeler Caruthers

(b) Address Alton, Mo.

17. (a) Burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bailey Cem.

18. (a) Signature of funeral director Jeland Carter

(b) Address Thayer, Mo.

19. (a) 10-24-47 (b) Michael Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1947 hour 2 minute 55 A. M.

21. I hereby certify that I attended the deceased from June 1
1947, to June 17, 1947;
that I last saw her alive on June 16, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
Central Hemorrhage

Due to _____

Due to Senility

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

Major findings: _____
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

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

Address Thayer, Mo. Date signed 6-19-47

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

RECEIVED

District

Case No. 6,

10475.6.2

District

10-17-47

Date Filed

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 255

Primary Registration District No. 4287

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town acton
(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)

3. (a) PRINT FULL NAME

Joel E. Olear

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

4. Sex F 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 _____

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

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) Oct-24-47 (b) M. W. C. Johnson
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1947 Day _____ Minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

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

SUPPLEMENTARY

S-35186