

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28858**

FILED SEP 29 1955

BIRTH NO. _____		REG. DIST. NO. <u>2</u>		PRIMARY REG. DIST. NO. <u>4009</u>		Registrar's No. <u>79</u>	
1. PLACE OF DEATH a. COUNTY <u>Andrew</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>			
b. CITY OR TOWN <u>Savannah, Mo.</u>		c. LENGTH OF STAY (In this place) <u>11 yrs</u>		c. CITY OR TOWN <u>Savannah</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Nichols Sanitorium</u>				e. STREET ADDRESS (If rural, give location) <u>Nichols Sanitorium</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Carl</u> c. (Last) <u>Ottman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 - 22 - 55</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3-11-1887</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doctoring</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Fairfax, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ransom Ottman</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Kimberline</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Ottman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW. I</u>		16. SOCIAL SECURITY NO. <u>491-28-5142</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. J.G. Ottman Savannah, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Atherosclerotic Heart disease</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>4200</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Sept 19</u> , 19 <u>55</u> , to <u>Sept 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 22</u> , 19 <u>55</u> , and that death occurred at <u>9:00 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <u>Gloyd A. Kerns, M.D.</u>				23b. ADDRESS <u>Savannah, Missouri</u>		23c. DATE SIGNED <u>Sept. 23, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>9-25-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Savannah City</u>		24d. LOCATION (City, town, or county) (State) <u>Savannah, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-23-55</u>		REGISTRAR'S SIGNATURE <u>William Sparks</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.M. Rich, Savannah, Mo.</u>			

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

OCT 18 1955

NOV 27 1955

JAN 27 1956

AUG 24 1960

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 *W. A. Rich*.....

Licensed Embalmer No. *473*.....

P. O. Address *Susanna*.....

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.