

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032711

FILED VS OCT 13 1959

Registration District No. 50 Primary Registration District No. 4239 Registrar's No. 223

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lee's Summit</b>		Length of stay in lb <b>8 yrs.</b>	c. CITY OR TOWN <b>Lee's Summit</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>312 North Douglas</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>312 North Douglas</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Baxter</b> Middle <b>Alexander</b> Last <b>Oliver</b>	4. DATE OF DEATH Month <b>Oct.</b> Day <b>9,</b> Year <b>1959</b>
---	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1877</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	----------------------------------	---	--	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher &amp; Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>	11. BIRTHPLACE (City and state or country) <b>Viola, Ark.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	---	--	---

13a. FATHER'S NAME <b>Robert Oliver</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Ellis</b>	14. NAME OF HUSBAND OR WIFE <b>Anna Oliver</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Anna Oliver, 312 No. Douglas, Mo.</b>	Address <b>Lee's Summit,</b>
--	--	---	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Dehydration &amp; Inanition</b>		<b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Intraoral And Pharyngeal Pemphigus</b>	<b>18 mos.</b>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 attended the deceased from <b>June 1958</b> to <b>9 Oct. 1959</b> and last saw him alive on <b>9 Oct. 1959</b> Death occurred at <b>9 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>M.D. Durrell M.D.</b> (Degree or title)	22b. ADDRESS <b>18 B. 3rd St. Lee's Summit, Mo.</b>	22c. DATE SIGNED <b>10/10/59</b>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 12, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Summit Cemetery</b>	23d. LOCATION (City, town, or county) <b>Lee's Summit, Mo.</b>	(State)
--	-----------------------------------	--	---	---------

24. FUNERAL DIRECTOR <b>Langsford Funeral Home, Lee's Summit, Mo.</b>	ADDRESS	MO.	25. DATE RECD. BY LOCAL REG. <b>10-10-1959</b>	26. REGISTRAR'S SIGNATURE <b>M. S. Langsford</b>
--	---------	-----	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6501 PT 130 SR

JUL 2 1962

APR 1 1962

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed D. B. Langsford

Licensed Embalmer No. 496

P. O. Address Lee's Summit

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.