

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9503**

Registration District No. **31**

Primary Registration District No. **5108**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Benton**
(b) City or town **Cole Camp Rural Williamstownship**
(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.....
In this community **74 1/2** years (Specify whether years, months or days)

3. (a) PRINT FULL NAME **August Holtzen**

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

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

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

7. Birth date of deceased **October 11th 1868**
(Month) (Day) (Year)

8. AGE: Years **74** Months **5** Days **13** If less than one day hr. min.

9. Birthplace **Cole Camp Rural Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business.....

12. Name **Cord Holtzen**

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

14. Maiden name **Catherine Schnakenberg**

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

16. (a) Informant **Walter Schroeder**

(b) Address **Cole Camp Mo R F D**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **March 26, 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation **Holy Cross Ev Cemetery**

18. (a) Signature of funeral director **S. J. Bickhoff**

(b) Address **Cole Camp Mo**

19. (a) **March 25-1943** (Date received local registrar) (b) **SUE SETOYER** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Benton**
(c) City or town **Cole Camp Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **6 Miles North East**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24th**
year **1943** hour **12** minute **15** A. M.

21. I hereby certify that I attended the deceased from **Jan 2** 1943, to **March 24** 1943, that I last saw him alive on **March 21** 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration

Due to **Arteriosclerosis**

Due to **Cachexia due to mal-nutrition**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 **2**

23. Signature **Byron L. Duncan** (M.D. or other) **80**

Address **Cole Camp, Mo** Date signed **3-25-43**

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

008

MOTHER FATHER

603

RECEIVED

District Health Officer No. 7

District File Number 3-43-72

Date Filed 7-9-43

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 B L Beckhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp 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.