

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 4356

FILED AUG 11 1944
Registration District No. 239

Primary Registration District No. 5-8-23430 b

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Parma

(c) Name of hospital or institution: None at Parma 3yc 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Life
years, months or days

3. (a) PRINT FULL NAME Etta Holtzhouser

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 Ernest Holtzhouser

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased November 9 1915
(Month) (Day) (Year)

8. AGE: Years 28 Months 8 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Percy Zyc

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

14. Maiden name Ferial

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

16. (a) Informant Augustine Ernest Holtzhouser

(b) Address Malden Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof July 22 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Malden

18. (a) Signature of funeral director Lander General Home

(b) Address Campbell Mo.

19. (a) 7/21/44 (Date received local registrar)

(b) ms. B. Rademaker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wentworth

(c) City or town Malden 3.5
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 3

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 th
year 1944 hour _____ minute 3.9 A.M.

21. I hereby certify that I attended the deceased from June 3 1944 to July 17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Decomp

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 9502

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 Steffensted (M. D. or other)

Address Parma Mo Date signed _____

1020

RECEIVED

District Health Office No. 2,

District File Number 844-1083

Date Filed 8-9-44

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, Md

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.