

U. S. No. 2
FORM-5443
Rev. 5-17-39
1 X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7390
Registrar's No. 31

FILED MAR 30 1945
Registration District No. 360

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Heraidea Washington Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital # 32
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 8 mos. 24 das.
(Specify whether)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Clara S. Holder

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 W

6. (b) Name of husband or wife Lois Holder

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

7. Birth date of deceased Dec 12 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 25
If less than one day _____ hr. _____ min.

9. Birthplace Lawrence Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James A. Jones

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

14. Maiden name Matilla Eskel

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

16. (a) Informant State Hospital Records

(b) Address Nevada, Mo.

17. (a) Removed (Burial, cremation, or removal) (b) Date thereof 2-8-45
(Month) (Day) (Year)

(c) Place: burial or cremation Wagonville, Mo.

18. (a) Signature of funeral director Erbaugh, Geo. Tom

(b) Address Nevada, Mo.

19. (a) 2-18-45 (Date received local registrar) (b) Hazel B. Bewick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

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

(d) Street No. 422 East College
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6
year 1945 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct. 31, 1944 to Feb 6, 1945
that I last saw her alive on Feb 6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Cerebral arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 43 W

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? _____

23. Signature Evelyn Griffin (M. D. or other) MD
Address Nevada, Mo. Date signed 2/6/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1331

RECEIVED

EXHIBIT No. 7

Exhibit 2-245-153

Date Filed

3-1-45

MAR 20 1945

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

Marsh Beehinger

Licensed Embalmer No.

2656

P. O. Address

Nevada, 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.