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UNITED STATES HEALTH DEPARTMENT  
STANDARD CERTIFICATE OF DEATH

State File No. 13220

FILED MAY 8 1947

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 300A

1. PLACE OF DEATH:  
 (a) County Greene  
 (b) City or town Rural Campbell twsp.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Greene County Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Month  
 In this community 7 Years  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME HENRY HOLTMAN  
 3. (b) If veteran, name war NO  
 3. (c) Social Security No. ✓

4. Sex male  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Maude Holtman  
 6. (c) Age of husband or wife if alive ? years  
 7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years ? Months Days If less than one day  
hr. min.

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

10. Usual occupation unk  
 11. Industry or business  
 12. Name unk  
 13. Birthplace unk 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name unk  
 15. Birthplace unk 9  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant County Farm Records  
 (b) Address Greene County, Mo.

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof April 21 1947  
(Month) (Day) (Year)  
 (c) Place: burial or cremation Haywood

18. (a) Signature of funeral director Fred C. Thieme  
 (b) Address Springfield, Mo.

19. (a) 4-8-47 (b) W E Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Greene 39  
 (c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 719 N. Campbell Ave. 6  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No) 1  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March April day 29th  
 year 1947 hour 11:50 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from March 22 1947 to March 29 1947  
 that I last saw him alive on March 29 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Primary Disease  
Myocarditis Chronic  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions 930  
(Include pregnancy within 3 months of death)  
 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? \_\_\_\_\_

23. Signature James P. Jones (M. D. or other) MD  
 Address Springfield, Mo. Date signed 4-8-47

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

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**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.....

*Ralph H. Thies*

Licensed Embalmer No. **3681**

P. O. Address **Springfield, 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.**