

S. No. 2
M-542
7-5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 17 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42321
State File No.
Registrars No. 16

Registration District No. 198 Primary Registration District No. 4311

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Callao
(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.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 6/
(a) State Mo. (b) County Macon
(c) City or town Callao
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Silas E. Holman
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 3
year 1947 hour 6:30 minute a M.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased 2 14 1956
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1944 to Nov. 1947
(that I last saw him alive on October 15, 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
91 8 19 ..hr. ..min.

Immediate cause of death.....
Chronic Myocardial Failure
Due to Infinite Age
Due to.....

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

Other conditions (Include program within 3 months of death)
Fractured Femur (1944)

10. Usual occupation Farmer
11. Industry or business.....
12. Name Squire Holman
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name No record
15. Birthplace.....
(City, town, or county) (State or foreign country)

Major findings:
Of operations.....
Of autopsy..... 1620

16. (a) Informant Orman Holman
(b) Address Callao, Mo.
17. (a) Burial (b) Date thereof 11 5 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation Mt. Zion Cem
18. (a) Signature of funeral director Albert Kummer
(b) Address Macon, Mo.
19. (a) Dec 9-47 (b) Josephine King
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) (c) Means of injury.....
23. Signature D. L. Rudea (M. D. or other) DR
Address Macon Mo Date signed 11/6/47

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

RECEIVED
District Health Officer No. 10
District File Number 12-47-1962
Date Filed DEC 16 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 me, or by Howard F. Myers, Registered Apprentice No. 768 working under my personal supervision.

Signed Albert Skinner
Licensed Embalmer No. 757
P. O. Address Macon 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.