

FILED AUG 24 1948

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **224**

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Columbia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Ellis Fischel State Cancer Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 days
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Andrain **4**
 (c) City or town Mexico, Mo. **1**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1417 N. Olive **2**
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No) **1**
 If yes, name country _____

3. (a) PRINT FULL NAME ELSIE MARIE HOLCOMB

3. (b) If veteran, name war ✓
 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife Hurlie 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 11 6 1908
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 9 13 hr. _____ min.

9. Birthplace Shamrock Mo. **0**
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name DK **9**
 { 13. Birthplace _____ (City, town, or county) (State or foreign country)
 { 14. Maiden name DK **9**
 { 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Hurlie V. Holcomb

(b) Address 1417 Olive Mexico Mo.

17. (a) Removal (b) Date thereof 8 19 48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville, Mo

18. (a) Signature of funeral director Chas. Arnold Jr

(b) Address Mexico, Mo

19. (a) 8-19-48 (b) Mrs. R.E. Palmer
 (Date received local registrar) (Registrar's signature) **31**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
 year 1948 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from April 9
 _____, 1948, to Aug 19, 1948;
 that I last saw her alive on 19 Aug., 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Tracheo-esophageal obstruction **1 mo**

Due to Hodgkins Disease **1 1/4 yr**

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

Major findings:
 Of operations None **44A**
 Of autopsy None

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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature Chas O Lockhart (M. D. or other) **0**
 Address Ellis Fischel Hosp Date signed 19 Aug **48**

RECEIVED
District Health Officer No. 9,
MILB. 23, 1948
District File Number
Date Filed

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 Everett R. Neal

Licensed Embalmer No. 4038

P. O. Address Mexico, 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.