

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Master - Advance
State File No. 42200A

FILED FEB 10 1950

BIRTH NO. _____ REG. DIST. NO. 391 PRIMARY REG. DIST. NO. 4565 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY: STODDARD		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: MO b. COUNTY: SCOTT	
b. CITY: (If outside corporate limits, write RURAL and give township) OR TOWN: BELL CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: SIKESTON MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 218 WILLIAM ST	

3. NAME OF DECEASED (Type or Print) a. (First): ALEXANDER	b. (Middle): HOLDER	c. (Last): HOLDER	4. DATE OF DEATH (Month) (Day) (Year) 12-30-1948
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5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED	8. DATE OF BIRTH: 12-28-1861	9. AGE (In years last birthday): 87	IF UNDER 1 YEAR: Months: _____ Days: 01	IF UNDER 24 HRS: Hours: _____ Min: _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER (RETIRED)	10b. KIND OF BUSINESS OR INDUSTRY: _____	11. BIRTHPLACE (State or foreign country): CALDWELL CO., KY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME: SPENCER HOLDER	13b. MOTHER'S MAIDEN NAME: UNKNOWN	14. NAME OF HUSBAND OR WIFE: ANNA LAURIE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME: _____ ADDRESS: _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Similarity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 1947, to **12-30**, 1948, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): E. C. Master	23b. ADDRESS: Advance, Mo	23c. DATE SIGNED: _____
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24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	24b. DATE: 12-31-48	24c. NAME OF CEMETERY OR CREMATORY: CITY	24d. LOCATION (City, town, or county) (State): SIKESTON MO
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DATE REC'D BY LOCAL REG.: 2-1-50	REGISTRAR'S SIGNATURE: Bernice Mann	25. FUNERAL DIRECTOR'S SIGNATURE: Welch Funeral Home Sikeston Mo	ADDRESS: _____
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(Licensed Embalmer's Statement on Reverse Side)

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

5. No. 300
10. 48

RECEIVED FEB 7 1950
District Health Office No. 2
District File Number 250-101
Case 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.