

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40875

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>127</u>		PRIMARY REG. DIST. NO. <u>5466</u>		Registrar's No. <u>1091</u>		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)				
a. COUNTY GREENE				a. STATE North Carolina b. COUNTY Guilford				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Spogfld-Rural-S. Campbell Twp				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greensboro				
c. LENGTH OF STAY (in this place)				d. STREET ADDRESS (If rural, give location)				
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners.				unknown				
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX		
a. (First) Odell			b. (Middle)			c. (Last) HOLDER		
6. COLOR OR RACE White			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married			8. DATE OF BIRTH 12-14-14		
9. AGE (In years last birthday) 34			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION			10b. KIND OF BUSINESS OR INDUSTRY Cotton mills		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Joe G. Holder			13b. MOTHER'S MAIDEN NAME Cora Adams			14. NAME OF HUSBAND OR WIFE Bertha Belle Holder		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME File, MCFP, Springfield, Missouri			
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis of lung, far advanced			8 yrs. 1 mo	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES				
				DUE TO (b) _____				
				DUE TO (c) _____				
				II. OTHER SIGNIFICANT CONDITIONS			002x	
				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 checked="" type="checkbox"/>		
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)				
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?				
22. I hereby certify that <u>the medical staff</u> attended the deceased from <u>January 24, 1948</u> , to <u>December 9, 1949</u> , that I last saw the deceased alive on <u>December 9, 1949</u> , and that death occurred at <u>3:00 P.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>[Signature]</u> (Degree or title) F. C. BRINK M. D., Clinical Director				23b. ADDRESS Medical Center for Federal Prisoners, Springfield, Mo.				23c. DATE SIGNED 12-9-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11 Dec 1949		24c. NAME OF CEMETERY OR CREMATORY Greensboro, N.C.		24d. LOCATION (City, town, or county) (State) Greensboro, N.C.		
DATE REC'D BY LOCAL REG. 12-13-49		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS Springfield, Mo				

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student
Student Embalmer

Signed Ralph H. Thine.....

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.