

FILED SEP 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30006**  
Registrar's No. **798**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b>	
c. LENGTH OF STAY (in this place)		0 394 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>1926 E. DALE</b>	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH
a. (First) <b>EMERY</b>	b. (Middle) <b>LEE</b>	c. (Last) <b>HOLDEN</b>	(Month) (Day) (Year) <b>SEPT. 9 1950</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
		<b>SINGLE</b>	<b>24 MAY 1921</b>
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
<b>29</b>		<b>MECHANIC</b>	<b>MISSOURI</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
<b>TYPEWRITER MECHANIC</b>		<b>MECHANIC</b>	<b>USA</b>
13a. FATHER'S NAME <b>WILLIAM HOLDEN</b>		13b. MOTHER'S MAIDEN NAME <b>GLESSA PHILLIPS</b>	14. NAME OF HUSBAND OR WIFE <b>✓</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>487-28-7947</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MRS. GLESSA NEWPORT - SPGFD. MO.</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Tuberculosis, Pulmonary, Intestinal, Renal.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
*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	
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 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)		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 I attended the deceased from <b>Aug 25, 1950, to Sept 9, 1950</b> , that I last saw the deceased alive on <b>Sept 9, 1950</b> , and that death occurred at <b>4:55 P. m.</b> , from the causes and on the date stated above.			
23. SIGNATURE <b>Thomas C. Coffey M.D.</b> (Degree or title)		23b. ADDRESS <b>Springfield, Mo</b>	
23c. DATE SIGNED <b>9-11-50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
<b>Burial</b>		<b>9/12/50</b>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
<b>Greenlawn Cem.</b>		<b>Springfield, Mo</b>	
DATE REC'D BY LOCAL REG. <b>9-12-50</b>		REGISTRAR'S SIGNATURE <b>W E Landry</b>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. K. Kingner &amp; Co. Spgfd. Mo</b>			

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

SEP 18 1957

FEB 5 1952

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Student \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4071

P. O. Address Springfield

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.