

FILED OCT 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33368**

BIRTH NO. _____ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 5522 Registrar's No. 22

0430

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

| | | | |
|---------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Hickory</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Dallas</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>CROSSTIMBERS</u> | c. LENGTH OF STAY (in this place) <u>2 YRS</u> | c. CITY (If outside corporate limits, write RURAL and give township) <u>URBANA</u> <u>03</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If rural, give location) <u>1</u> | |

| | | | | |
|-------------------------------------|------------------------|------------------------|-----------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>MARY</u> | b. (Middle) <u>ANN</u> | c. (Last) <u>Holt</u> | 4. DATE OF DEATH (Month) (Day) (Year) |
|-------------------------------------|------------------------|------------------------|-----------------------|---------------------------------------|

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|-----------------|----------------------------|------------------------------------------------------------------|------------------------------------|-------------------------------------------|-----------------------------|-----------------------------|
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u> | 8. DATE OF BIRTH <u>FEB-6-1870</u> | 9. AGE (In years last birthday) <u>81</u> | IF UNDER 1 YEAR Months Days | IF UNDER 12 HRS. Hours Min. |
|-----------------|----------------------------|------------------------------------------------------------------|------------------------------------|-------------------------------------------|-----------------------------|-----------------------------|

| | | | |
|-----------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------|---------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Hickory Co. Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
|-----------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------|---------------------------------------------|

| | | |
|-------------------------------------------|---------------------------------------------|--------------------------------------------------|
| 13a. FATHER'S NAME <u>John Jackson</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>N. J. Holt</u> |
|-------------------------------------------|---------------------------------------------|--------------------------------------------------|

| | | | |
|----------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------|---------------------------|
| 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. | 17. INFORMANT'S SIGNATURE OR NAME <u>MR. HARRY Holt</u> | ADDRESS <u>H.C. Mo</u> |
|----------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------|---------------------------|

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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, asthenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Febrile Hemorrhage</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>57 days</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension & Diabetes</u> | | |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|------------------------|-------------------------------------------------|--------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>331X</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>11:30 AM</u> | 21e. INJURY OCCURRED WHILE AT () NOT WHILE AT WORK () | 21f. HOW DID INJURY OCCUR? |
|-----------------------------------------------------------------|---------------------------------------------------------|----------------------------|

22. I hereby certify that I attended the deceased from Jan 1, 1947, to Oct 8, 1951, that I last saw the deceased alive on Oct 8, 1951, and that death occurred at _____ m., from the causes and on the date stated above.

| | | | |
|--------------------------------------------|-------------------|----------------------------------|----------------------------------------|
| 23a. SIGNATURE <u>L. A. Glover M.D.</u> | (Degree or title) | 23b. ADDRESS <u>Urbana Mo</u> | 23c. DATE SIGNED <u>Oct 11-1951</u> |
|--------------------------------------------|-------------------|----------------------------------|----------------------------------------|

| | | | |
|------------------------------------------------------------|--------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Oct-8-1951</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Fisher Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Hickory Co MO</u> |
|------------------------------------------------------------|--------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------|

| | | | | |
|---------------------------------------------|----------------------------------------------|-----|----------------------------------------------------------|-----------------------------|
| DATE REC'D BY LOCAL REG. <u>10-15-51</u> | REGISTRAR'S SIGNATURE <u>Mary Johnson</u> | 464 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Laughman-Ryan</u> | ADDRESS <u>Urbana Mo</u> |
|---------------------------------------------|----------------------------------------------|-----|----------------------------------------------------------|-----------------------------|

RECEIVED OCT 20 1951

DISTRICT HEALTH OFFICE No. 3

District File Number

OCT 20 1951

see 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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Allen W Vaughan*

Signed.....
Student Embalmer

Licensed Embalmer No. *4156*

P. O. Address *Urbana*

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.