

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5186**

FILED MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Ray</u>	
b. CITY OR TOWN <u>Excelsior Springs</u>		c. CITY OR TOWN <u>Lawson</u>	
c. LENGTH OF STAY (In this place) <u>8 hrs</u>		d. STREET ADDRESS (If rural, give location) <u>None</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Excelsior Spring Hospital</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u>		b. (Middle) <u>NATHAN</u>	
c. (Last) <u>HOLT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 1 1953</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 29 1879</u>	
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Clay Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Holt</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Brascott</u>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>LeRoy Holt Lawson</u>		ADDRESS <u>Mo</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shock</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Burns about head & face</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>E 9160 16</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOME/ETC <u>Burn</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>	
21c. CITY, TOWN, OR TOWNSHIP <u>Lawson 089</u> (COUNTY) <u>Ray</u> (STATE) <u>Mo</u>			
21d. TIME OF INJURY <u>March 1 1953 1P.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Gas explosion in room.</u>			
22. I hereby certify that I attended the deceased from <u>March 1, 1953</u> , to <u>March 1, 1953</u> , that I last saw the deceased alive on <u>March 1, 1953</u> , and that death occurred at <u>8 A.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Robert E. Buchner</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Lawson Mo</u>	
23c. DATE SIGNED <u>March 1953</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Mar 3 '53</u>		24b. DATE <u>Mar 3 '53</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>	
DATE REC'D BY LOCAL REG. <u>3/7/53</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Jerman - Prichard</u>		ADDRESS <u>Lawson Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

00028

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

Lance K. Jarnan

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs, 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.