

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9164**

FILED **APR 3 1953**
BIRTH NO. _____ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **3012** Registrar's No. **39**

6002
1

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

1. PLACE OF DEATH a. COUNTY Clay				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Arkansas b. COUNTY Faulkner			
b. CITY (If outside corporate limits, write RURAL and give township) Excelsior Springs		c. LENGTH OF STAY (in this place) 2 years		c. CITY (If outside corporate limits, write RURAL and give township) Biloria		8030	
d. FULL NAME OF HOSPITAL OR INSTITUTION 111 1/2 East Broadway				d. STREET ADDRESS (If rural, give location) None			
3. NAME OF DECEASED (Type or Print) a. (First) James Robert b. (Middle) Golly c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) March 25-1953				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 1-1865	
9. AGE (In years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of time, even if retired) Doctor of Medicine		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Enders Arkansas	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Tom Golly		13b. MOTHER'S MAIDEN NAME Melissa McDew		14. NAME OF HUSBAND OR WIFE Susan Hogue Golly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Sam Golly, Nancy, Arkansas			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage Esophageal Varices ANTECEDENT CAUSES DUE TO (b) Cerebral Hemorrhage DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day years
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X					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) (Minute)		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 5/29 , 19 52 , to 3-25 , 19 52 , that I last saw the deceased alive on 5/25 , 19 53 , and that death occurred at 4:00 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE Reginald H. Libbman MD (Degree or title)				23b. ADDRESS Excelsior Springs Mo		23c. DATE SIGNED 3/26/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE March 27-53		24c. NAME OF CEMETERY OR CREMATORY McNew Cemetery		24d. LOCATION (City, town, or county) (State) Centerville, Arkansas	
DATE REC'D BY LOCAL REG. 3/28/53		REGISTRAR'S SIGNATURE Baroline Huthing		25. FUNERAL DIRECTOR'S SIGNATURE Virgil Hope Excelsior Springs Mo.			

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

Carl Rapp

Licensed Embalmer No. *23458*

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.