

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

39559

State File No. _____

FILED DEC 3 - 1953

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 168

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lebanon</u>				c. LENGTH OF STAY (in this place) <u>0532</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wallace Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>379 N. Jefferson</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Theresa</u> b. (Middle) <u>R.</u> c. (Last) <u>Holt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 18, 1953</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>"</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 23, 1871</u>		9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months	IF UNDER 14 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Laclede Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jacob Hartmiller</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Fisher</u>			14. NAME OF HUSBAND OR WIFE <u>T. 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. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>T. J. Holt, Lebanon, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> <u>Left Hemiplegia</u></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic HT Disease</u></p>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				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 I attended the deceased from <u>June 1, 1953</u> , to <u>Nov 18, 1953</u> , that I last saw the deceased alive on <u>11-18, 1953</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul A. Jenkins M.D.</u>				23b. ADDRESS <u>Knights Bldg Lebanon Mo</u>		23c. DATE SIGNED <u>11-20-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/20/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Lebanon, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11-23-1953</u>		REGISTRAR'S SIGNATURE <u>Phella L. May</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer</u>		ADDRESS <u>Lebanon</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

received NOV 28 1953

LaSalle County Health Unit

File No. 11-53-174

Date Filed DEC 1 1953

FEB 26 1957

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 S. R. Palmer

Licensed Embalmer No. 2202

P. O. Address Channah nd

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.