

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED JUL 12 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 178

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton Mo.</u>	c. LENGTH OF STAY (In this place) <u>4 hrs 30 mo</u>	c. CITY OR TOWN <u>Columbia Mo</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>State Hospital #1, Fulton Mo</u>		e. STREET ADDRESS (If rural, give location) <u>D.K.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HANS</u>	b. (Middle)	c. (Last) <u>HOLM</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 7, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>July 20, 1880</u>	9. AGE (In years last birthday) <u>73</u>	IF OVER 1 YEAR Months <u>11</u> Days <u>17</u>	IF OVER 48 HRS. Hours _____ Min. _____
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>Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Peter Holm</u>	13b. MOTHER'S MAIDEN NAME <u>Marion Nischen</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records of State Hospital #1, Fulton Mo</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho-Pneumonia, Bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	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. <u>Generalized Arteriosclerosis</u>		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>491X</u> YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Sept 17, 1953, to July 7, 1954, that I last saw the deceased alive on July 7, 1954, and that death occurred at 2:30 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Thomas J. Nichols M.D.</u> (Degree or title)	23b. ADDRESS <u>State Hospital #1, Fulton Mo</u>	23c. DATE SIGNED <u>7-7-1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 9, 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Columbia Cem. Columbia Mo.</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>July 7-1954</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	426-	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Home</u>	ADDRESS <u>Columbia</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *Tom McLaugh*.....

Licensed Embalmer No. *406*.....

P. O. Address *Columbia*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.