

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25613

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>RAY</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>EXCELSIOR SPRINGS</u>	c. LENGTH OF STAY (In this place) <u>1 DAY</u>	c. CITY OR TOWN <u>RR #2 LAWSON,</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSP.</u>		STREET ADDRESS (If rural, give location) <u>5 MILES EAST OF LAWSON</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>RHODA</u>	b. (Middle) <u>BELL</u>	c. (Last) <u>HOLMAN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUG 14 1955</u>
-------------------------------------	-------------------------	-------------------------	-------------------------	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB 11, 1892</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>POLO, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	--	--

13a. FATHER'S NAME <u>MARCUS LEABO</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ED HOLMAN</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>ED HOLMAN</u>	ADDRESS _____
--	-------------------------------------	--	---------------

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>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>		
	DUE TO (c) <u>331X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

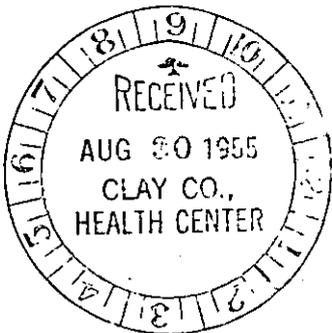
22. I hereby certify that I attended the deceased from 13 Aug 1955, to 14 Aug 1955, that I last saw the deceased alive on 14 Aug 1955, and that death occurred at 4:30 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Deane C Sanders M.D.</u> (Degree or title)	23b. ADDRESS <u>Excelsior Springs, Mo.</u>	23c. DATE SIGNED <u>8-16-55</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>AUG 17, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL</u>	24d. LOCATION (City, town, or county) (State) <u>EX SPRINGS, MO</u>
---	-------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>8/21/55</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>PRICHARD FUNERAL HOME</u>	ADDRESS <u>EX SPRINGS MO.</u>
---	---	---	-------------------------------

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



OCT 7 1958

---

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 *Ralph E Van Landingham*

Licensed Embalmer No. *400*

*Galien Springs, Mo*  
P. O. Address.....

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.