

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9213**  
Registrar's No. **55**

FILED APR 2 - 1957

BIRTH NO. _____		REG. DIST. NO. <b>170</b>		PRIMARY REG. DIST. NO. <b>3033</b>		Registrar's No. <b>55</b>			
1. PLACE OF DEATH a. COUNTY <b>Laclede</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b>					
b. CITY (If outside corporate limits, write RURAL and give township) <b>Lebanon</b>		c. LENGTH OF STAY (in this place) <b>2 days</b>		c. CITY OR TOWN <b>Sleepers</b>		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 <b>Wallace Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>No St Address 0530</b>					
3. NAME OF DECEASED (Type or Print) <b>Letha Esther Holman</b>			4. DATE OF DEATH <b>Mar. 21, 1957</b>						
a. (First)		b. (Middle)		c. (Last)					
5. SEX <b>F</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>May 23 1900</b>			
9. AGE (In years last birthday) <b>56</b>		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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <b>Stoutland Mo.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13a. FATHER'S NAME <b>James Wilson</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca M. Commas</b>		14. NAME OF HUSBAND OR WIFE <b>Charley J. Holman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Charley J. Holman</b>			ADDRESS <b>Sleepers Mo.</b>	
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 minutes</b>	
				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. <b>diabetes mellitus</b>				<b>7 years</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <b>2</b> 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) <b>4201</b>		(COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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 <b>July 1950</b> , to <b>March 21, 1957</b> , that I last saw the deceased alive on <b>March 21, 1957</b> , and that death occurred at <b>5:45 P. M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>James L. Hope, M.D.</b>				23b. ADDRESS <b>Lebanon, Mo.</b>		23c. DATE SIGNED <b>3/29/57</b>			
24a. BURIAL, CREMATION/REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>3/24/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Honey Cemetery near Stoutland, Mo.</b>		24d. LOCATION (City, town, or county) _____ (State) _____			
DATE REC'D BY LOCAL REG. <b>3-29-1957</b>		REGISTRAR'S SIGNATURE <b>Hella C. May</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Halman Funeral Home</b>		ADDRESS <b>Lebanon Mo.</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD 0

440

Received 4-1-57  
Laclede County Health Unit  
File No. 25  
Date Filed 4-1-57

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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 Darsey M. Howe

Licensed Embalmer No. 422

P. O. Address Lebanon,

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.