

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9662**

FILED APR 4 - 1957

BIRTH NO. _____ REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **4413** Registrar's No. **43**

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

1. PLACE OF DEATH a. COUNTY Pike <i>0820</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pike	
b. CITY OR TOWN Frankford	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Frankford	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		STREET ADDRESS (If rural, give location) 0820	

3. NAME OF DECEASED (Type or Print) a. (First) OTHO	b. (Middle) WILLIAM	c. (Last) HOLMAN	4. DATE OF DEATH (Month) (Day) (Year) MARCH 21 1957
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5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB. 18-1873	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian Doctor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Frankford Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James J. Holman	13b. MOTHER'S MAIDEN NAME Elizabeth McPune	14. NAME OF HUSBAND OR WIFE Rebecca Holman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (See no. or unknown) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. J.R. Hutcherson	ADDRESS Frankford Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Sigmoid		INTERVAL BETWEEN ONSET AND DEATH
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 153x	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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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?
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22. I hereby certify that I attended the deceased from **Apr 19 1957** to **Mar 21 1957**, that I last saw the deceased alive on **Mar 20 1957**, and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. P. Hansen D.O.	(Degree or title)	23b. ADDRESS Frankford Mo.	23c. DATE SIGNED 3/22/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE March 23-57	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) (State) Frankford Mo.
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DATE REC'D BY LOCAL REG. Mar. 30, 1957	REGISTRAR'S SIGNATURE Bernice Collier	25. FUNERAL DIRECTOR'S SIGNATURE Fields-Meyers	ADDRESS Frankford Mo.
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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.....
Jose Fields Megaw

Licensed Embalmer No. *4093*

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