

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28619

STATE FILE NUMBER

FILED SEP 10 1957

Registration District No. 171 Primary Registration District No. 4268 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mayview</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Mayview, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on <u>340</u> Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Monroe</u> Last <u>Holman</u>			4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1864</u>	9. AGE (In years last birthday) <u>92</u>	IF UNDER 1 YEAR Month <u>9</u> Day <u>25</u> IF UNDER 24 HRS. Hours <u>   </u> Min. <u>   </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Rock Springs, Ky.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Henry Holman</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Jane Spradling</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.		17. INFORMANT Address <u>Mrs. C. M. Holman</u> <u>Mayview, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic encephalopathy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>6 months</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>7-3-53</u> to <u>7-13-57</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>7-12-57</u> Death occurred at <u>6:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Wilbur E. Fulbrason M.D.</u>			22b. ADDRESS <u>Higginsville Mo.</u>		22c. DATE SIGNED <u>8-28-57</u>
23a. BURIAL, CREMATION, REBURYAL (S/P/Y) <u>Burial</u>		23b. DATE <u>8-15-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>Corder, Missouri</u>
24. FUNERAL DIRECTOR <u>F. R. Hoefler</u>		ADDRESS <u>Higginsville</u>		25. DATE RECD. BY LOCAL REG. <u>Sept. 7, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard form prepared by the State Department of Health. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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