

FILED OCT 9 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4390

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN YANAS CITY		c. CITY OR TOWN HICKMAN MILLS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MEMORAH HOPT		d. STREET ADDRESS (If outside, give location) 7224 E 99th	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR HOLTZCLAW		4. DATE OF DEATH Month Day Year 9 20 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-81
9a. AGE (In years last birthday) 76		9b. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (City and state or country) HIGBEE MO		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME ALEXANDER HOLTZCLAW		13b. MOTHER'S MAIDEN NAME THEODOSIA WARE	
14. NAME OF HUSBAND OR WIFE KEZIA PENNOS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. P		17. INFORMANT Mrs Opa FUGET, Hickman Mills, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular occlusion. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension 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 4 days 20 year 33 1/2
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 Month, Day, Year a.m. p.m.	
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 Hickman Mills, MO		20g. COUNTY STATE	
21. I attended the deceased from 9/16/57 to 9/20/57 and last saw her/him alive on 9/20/57 Death occurred at 2:50 PM on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Irving H. Clark M.D.	
22b. ADDRESS Hickman Mills, MO		22c. DATE SIGNED 9/21/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 9-21-57	
23c. NAME OF CEMETERY OR CREMATORY NEW HOPE		23d. LOCATION (City, town, or country) (State) Hig BEE MO	
24. FUNERAL DIRECTOR Sheil Funeral Home A.C. Inc.		25. DATE RECD. BY LOCAL REG. 9-21-57	
26. REGISTRAR'S SIGNATURE Irene Minshall			

Irving H. Clark USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Every answer, whether or not the only standard nomenclature mention is, must be causally related. No symptoms will be listed.

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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 *Richard E. Carroll*

Licensed Embalmer No. *4829*
P. O. Address *RC 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.