

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47038

STATE FILE NUMBER

FILED DEC 16 1957

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 7

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Millan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Boynton</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sul. Co. M. Hospt</u>			Length of stay in lb <u>1 hr</u>	d. STREET ADDRESS <u>Jackson Twp</u> (If outside, give location) <u>CR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Holloway</u> Last <u>Holloway</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1957</u>						
5. SEX <u>F-m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-9-1869</u>		9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>28</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>at home on farm</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Glasgow Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>us</u>			
13. FATHER'S NAME <u>Albert Huffman</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Munnally</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>-</u>		17. INFORMANT Address <u>Delsie Holloway Boynton 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>Cerebral Hemorrhage</u> <u>arteriosclerosis. Hypertension Hard Chole</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>4:200</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 hr.</u> <u>109.</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.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>										
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 <u>Millan</u>		COUNTY <u>Sullivan</u>		STATE <u>Mo.</u>		
21. I attended the deceased from <u>Jan 53</u> to <u>147/57</u> and last saw <u>her</u> alive on <u>147/57</u> Death occurred at <u>7:10</u> <u>am</u> on the date stated above; and to the best of my knowledge, from the causes stated.										
22. SIGNATURE <u>Joseph S. Graybill M.D.</u> (Degree or title)				22b. ADDRESS <u>Millan Mo</u>				22c. DATE SIGNED <u>12/8/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12-10-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem</u>		23d. LOCATION (City, town, or county) <u>Boynton</u>		(State) <u>Mo</u>		
24. FUNERAL DIRECTOR <u>Schoopes</u> <u>August Schoep</u>			ADDRESS <u>Millan Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-11-57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckwith</u>			

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... *Dwight Schaefer*

Licensed Embalmer No. *2667*

P. O. Address *Walden -*

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.