

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026339
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 52

S. 300
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1. PLACE OF DEATH a. COUNTY <u>Morgan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Versailles</u> 6710 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S. Oak St.</u>		Length of stay in lb <u>15 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>S. Oak St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>M.</u> Last <u>Holt</u>			4. DATE OF DEATH Month <u>July</u> Day <u>16</u> , Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1878</u>
9. AGE (In years of birthday) <u>79</u>		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) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hickory Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.U.</u>		13. FATHER'S NAME <u>H. M. Holt</u>	
13b. MOTHER'S MAIDEN NAME <u>Bonnie Lindsey</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel Spencer</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>Unknown</u>	17. INFORMANT <u>Lester Holt</u> Address <u>Buffalo, 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 Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>			<u>5 years</u>
DUE TO (c) _____			<u>4200</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2.</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>March 1958</u> to <u>July 16 1958</u> and last saw ^{her} him alive on <u>July 16 1958</u> Death occurred at <u>9450</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Jack Gunn MD</u> (Degree or title)		22b. ADDRESS <u>Versailles, Mo.</u>	22c. DATE SIGNED <u>5-17-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>19 July 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>
		23d. LOCATION (City, town, or county) <u>Versailles, Mo.</u>	(State)
24. FUNERAL DIRECTOR <u>W. F. Kidwell</u>		ADDRESS <u>Versailles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-19-58</u>
		26. REGISTRAR'S SIGNATURE <u>J L Wash</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

1 AUG 8 1958

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 *Raymond C. Forbes*

Licensed Embalmer No. *4626*

P. O. Address. *V. ...*

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.