

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035452

STATE FILE NUMBER

FILED OCT 27 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 469

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Columbia</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 <u>UNIV. of Mo. Med Center</u>			Length of stay in 1b <u>6 1/2 Hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>604 E. Ash</u>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miller Edward Holman</u>				4. DATE OF DEATH Month Day Year <u>Oct 18 1958</u>			
5. SEX. <u>Male</u>	6. COLOR OR RACE <u>2 NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1903</u>		9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No.</u>		11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Holman</u>				14. MOTHER'S MAIDEN NAME <u>Sally A. Miller</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>486-1227x9</u>		17. INFORMANT <u>Aazel JENNINGS</u> Address <u>Columbia, 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>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>491X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EXOGENOUS OBESITY</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>1</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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		COUNTY	STATE
21. I attended the deceased from <u>10-18-58</u> to <u>10-18-58</u> and last saw him alive on <u>10-18-58</u> Death occurred at <u>11:45</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Miane Burkhardt M.D.</u>				22b. ADDRESS <u>U. of Missouri Medical Center, Columbia, Mo.</u>		22c. DATE SIGNED <u>10-19-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 23, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>C. Ash</u>		23d. LOCATION (City, town, or county) <u>Columbia, Mo.</u>			(State)
24. FUNERAL DIRECTOR <u>Mrs. Stuart Parker, Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Oct 23 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		

(Licensed Embolmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

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All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. 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.

MEDICAL CERTIFICATION

6621071221

OCT 29 195

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 _____
Georgett Green

Licensed Embalmer No. 42

P. O. Address *Marshall*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.