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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-035852

STATE FILE NUMBER

FILED OCT 28 1958 Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 307

1. PLACE OF DEATH
a. COUNTY Cole
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jefferson City, Mo. Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Marys Hospital Length of stay in lb

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cole
c. CITY OR TOWN Jefferson City, Mo. Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) 026 R. R. # 3 Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First JOSEPH Middle FRANK Last HOLZER

4. DATE OF DEATH Month Day Year OCT. 23, 1958

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]
8. DATE OF BIRTH March 19, 1874
9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months 7 Days 4 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Marys Home, Mo 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Holzer
13b. MOTHER'S MAIDEN NAME Marie Brown
14. NAME OF HUSBAND OR WIFE Katherine Goeller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs. Katherine Holzer J C Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis — years
DUE TO (c) 4201
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 [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 Oct 23/58, to Oct 23/58 and last saw her/him alive on Oct 23/58
Death occurred at 1 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Green W Taylor 0
22b. ADDRESS Jefferson City, Mo
22c. DATE SIGNED 10-24-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10/25/58
23c. NAME OF CEMETERY OR CREMATORY Resurrection
23d. LOCATION (City, town, or county) (State) Jefferson City, Mo.

24. FUNERAL DIRECTOR Sylvester Dulle ADDRESS J C Mo.
25. DATE RECD. BY LOCAL REG. 25 October 1958
26. REGISTRAR'S SIGNATURE R. P. Dorris, MD-MR

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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OCT 29 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 Sylvester Quille

Licensed Embalmer No. 4321

P. O. Address Jefferson City, M

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.