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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000499

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 12

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Cape Girardeau — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Southeast Hospital — Length of stay in Ib 3 hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cape Girardeau
c. CITY OR TOWN Burfordville — Inside Limits Yes ☒ No ☒
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First LIZZIE Middle — Last HOLMES

4. DATE OF DEATH Month Jan Day 2, Year 1959

5. SEX Female **6. COLOR OR RACE** white **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐ **8. DATE OF BIRTH** Nov. 23, 1871 **9. AGE** (In years last birthday) 87 **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) Housekeeping **10b. KIND OF BUSINESS OR INDUSTRY** none **11. BIRTHPLACE** (City and state or country) Burfordville Mo. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13a. FATHER'S NAME August Overbeck **13b. MOTHER'S MAIDEN NAME** Caroline Voyelsong **14. NAME OF HUSBAND OR WIFE** Peter H. Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) none **16. SOCIAL SECURITY NO.** none **17. INFORMANT** Anita Loennecke Address Cape Girardeau

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension — 10 yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 334x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 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 1947, to 1-2-59 and last saw her alive on 1-2-59
Death occurred at 3:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E.F. McDonald, MD. **22b. ADDRESS** Jackson, Mo. **22c. DATE SIGNED** 1-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE** Jan 4, 1959 **23c. NAME OF CEMETERY OR CREMATORY** Russell Heights **23d. LOCATION** (City, town, or county) Jackson (State) Mo

24. FUNERAL DIRECTOR R. Miller Jackson Mo **ADDRESS** **25. DATE RECD. BY LOCAL REG.** Jan 19 1959 **26. REGISTRAR'S SIGNATURE** Mrs. Homer Cooper

(Licensed Embalmer's Statement on Reverse Side)

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 Lane C. Crawford

Licensed Embalmer No. 4327

P. O. Address Jackson, Mi

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.