

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001120  
STATE FILE NUMBER

FILED JAN 6 1959 Station District No. 138 Primary Registration District No. Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <b>Hickory</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Hickory</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cross Timbers</b>		c. CITY OR TOWN <b>Cross Timbers</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb <b>6 years.</b>		<b>2 miles north C.T.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Ellick Holt</b>			4. DATE OF DEATH Month Day Year <b>JAN 3 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>69</b> Months Days Hours Min. <b>6 14</b>
11. BIRTHPLACE (City and state or country) <b>Benton Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>JACOB MARION Holt</b>		13b. MOTHER'S MAIDEN NAME <b>Mary E. Parrott</b>	
14. NAME OF HUSBAND OR WIFE <b>Ella Holt</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>492-18-3882</b>		17. INFORMANT Address <b>Ella Holt Cross Timbers, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - Primary Prostate 1 yr.</b> DUE TO (b) <b>Secondary Spinal Cord.</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>177X</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.		20d. INJURY OCCURRED WHILE AT <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 <b>Oct 1-58</b> to <b>Jan 2-59</b> and last saw her/him alive on <b>Jan 1-59</b> Death occurred at <b>6:00 P.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>C. O. Baskley No 2</b>		22b. ADDRESS <b>Warshaw, Mo</b>	
22c. DATE SIGNED <b>Jan 5-59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>Jan 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clint Springs Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Clint Springs Benton Co. Mo.</b>		24. FUNERAL DIRECTOR ADDRESS <b>John F. Reser Warshaw</b>	
25. DATE RECD. BY LOCAL REG. <b>Jan 3-1959</b>		26. REGISTRAR'S SIGNATURE <b>May Johnson</b>	

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.

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 *John F. Reser* .....

Licensed Embalmer No. *4098* .....  
P. O. Address *Warsaw* .....

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.