Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004106
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 326 Primary Registration District No. 4482 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY Scotland	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scotland
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Memphis — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Memphis 0990 0 — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b 6 yrs	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Mary	Middle: Elizabeth	Last: Holcomb	4. DATE OF DEATH Month Day Year: Jan. 22 1959
5. SEX: female	6. COLOR OR RACE: white	7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH: 10-29-1866
9. AGE (In years last birthday): 92	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): house keeping	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Scotland County, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S.A
13a. FATHER'S NAME: Eli Vaught	13b. MOTHER'S MAIDEN NAME: not known	14. NAME OF HUSBAND OR WIFE: William J. Holcomb	
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: Aubria Holcomb Address: Keokuk, Ia	

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.

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) Pneumonia (Hypostatic) — INTERVAL BETWEEN ONSET AND DEATH: 14 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ateriesclerosis& cerebral Hemorrhage 2 years ago 331X

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 Jan 16, to Jan 22,59 and last saw her/him alive on Jan 21 1959

Death occurred at 9:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. E. Symonds DO 2	22b. ADDRESS: Memphis, Missouri	22c. DATE SIGNED: Jan 24, 59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: Jan 24, 1959	23c. NAME OF CEMETERY OR CREMATORY: Richland cemetery	23d. LOCATION (City, town, or county) (State): Scotland Co. Mo.
24. FUNERAL DIRECTOR: D.W. Payne & Sons	ADDRESS: Memphis, Mo.	25. DATE RECD. BY LOCAL REG.: 1-26-59	26. REGISTRAR'S SIGNATURE: Vera G. Turner

(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 .....

Licensed Embalmer No. 2550

P. O. Address Memphis, Mo.

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.