THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004301
STATE FILE NUMBER

JAN 26 1959 Registration District No. 373 Primary Registration District No. 6269 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY WEBSTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD OZARK — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WEBSTER CO. HOME — Length of stay in 1b 5 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY WEBSTER
c. CITY OR TOWN MARSHFIELD 1120 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First FRED Middle J Last HOLCOMB

4. DATE OF DEATH Month JAN Day 4 Year 1959

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAR 15 1884
9. AGE (In years last birthday) 74 — 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) FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME J.T. HOLCOMB
13b. MOTHER'S MAIDEN NAME SARAH POINDEXTER
14. NAME OF HUSBAND OR WIFE KATIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT KATIE HOLCOMB Address MARSHFIELD

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) PULMONARY EDEMA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CEREBRAL THROMBOSIS
DUE TO (c) ARTERIOSCLEROSIS
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 6/1/55, to 1/4/59 and last saw ~~her~~ him alive on 1/4/59
Death occurred at 11:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) DD
22b. ADDRESS Marshfield, Mo.
22c. DATE SIGNED 1/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 1-8-1959
23c. NAME OF CEMETERY OR CREMATORY ST LUKE
23d. LOCATION (City, town, or county) WEBSTER CO (State) MO

24. FUNERAL DIRECTOR BARBER-EDWARDS ADDRESS MARSHFIELD
25. DATE RECD. BY LOCAL REG. JAN 20 1959
26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 George Stroph

Licensed Embalmer No. 3161

P. O. Address Mtn Green

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.