

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008810

STATE FILE NUMBER

FILED APR 9 1959

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 106

1. PLACE OF DEATH a. COUNTY <i>Cole</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cole</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>JEFFERSON CITY</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>JEFFERSON CITY</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>108 E. FRANKLIN</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>108 E. FRANKLIN</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Penn</i> Last <i>Holt</i>			4. DATE OF DEATH Month <i>April</i> Day <i>7</i> Year <i>59</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29-1895</i>	9. AGE (In years last birthday) <i>63</i>	IF UNDER 1 YEAR Months <i>8</i> Days <i>8</i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>State Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTH PLACE (City and state or country) <i>New Bloomfield Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Wm. H. Holt</i>		13b. MOTHER'S MAIDEN NAME <i>Catherine Vaughan</i>		14. NAME OF HUSBAND OR WIFE <i>Effie Holt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>492-36-9386A</i>	17. INFORMANT <i>Mrs W. P. Holt</i> 108 Address <i>A. FRANKLIN</i> <i>JEFFERSON CITY MO</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Colon</i>					INTERVAL BETWEEN ONSET AND DEATH <i>5 year</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<i>1538</i>
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 <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. Month, Day, Year _____					
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 <i>1957</i> to <i>4-7-59</i> and last saw him alive on <i>4-7-59</i> Death occurred at <i>1:30 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Wm. A. Taylor M.D.</i>			22b. ADDRESS <i>Jefferson City</i>		22c. DATE SIGNED <i>4-8-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>APR 19-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Bloomfield</i>		23d. LOCATION (City, town, or county) (State) <i>New Bloomfield Mo</i>
24. FUNERAL DIRECTOR <i>Claypool Sec.</i>		ADDRESS <i>New Bloomfield Mo</i>		25. DATE RECD. BY LOCAL REG. <i>8 April 1959</i>	26. REGISTRAR'S SIGNATURE <i>R. P. Norris, M.D. M.P.</i>

(Licensed Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

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-57

1

Director, coroner, etc.; most are only statements. 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 *LeRoy Claypool*

Licensed Embalmer No. *4412*

P. O. Address *New Blumf*

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.