

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012030

STATE FILE NUMBER

FILED MAR 18 1959

Registration District No. 361 Primary Registration District No. 4515 Registrar's No. 21

300
-57

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Green City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S.C. Memorial Hosp. 2 mo.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>7 mi. N. of Green City</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Alger</u> Last <u>Hollenbeck</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-26-1883</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	11. BIRTHPLACE (City and state or country) <u>Don't know</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John Hollenbeck</u>		13b. MOTHER'S MAIDEN NAME <u>Laura (don't Know)</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Gordon Lunsford, Green City, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the sigmoid</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
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)					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 <u>December 1958</u> to <u>Feb. 21, 1959</u> and last saw him alive on <u>Feb. 21, 1959</u> Death occurred at <u>11:09</u> AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. W. Simpson D.O.</u> (Degree or title)			22b. ADDRESS <u>Milan, Missouri</u>		22c. DATE SIGNED <u>Feb. 23 '59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burnett Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sullivan Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Glenn E. Kent & Son, Green City, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>3-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Karl R. Kent*

Licensed Embalmer No. *4689*
P. O. Address *Green City, 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.