

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013978

STATE FILE NUMBER
Registral's No. 46

REC'D APR 28 1959

Registration District No. 383 Primary Registration District No. 5655

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-57

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		c. CITY OR TOWN Charleston	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium		d. STREET ADDRESS (If outside, give location) Route 2	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
Eddie McHolmes			March 31, 1959		

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1915	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Cotton picking	11. BIRTHPLACE (City and state or country) Arizona	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME McHolmes	13b. MOTHER'S MAIDEN NAME Eula Mae Lovelace	14. NAME OF HUSBAND OR WIFE Marie
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT San. records, Mo. State San., Mt. Vernon, Mo.	Address
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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 hemoptysis		INTERVAL BETWEEN ONSET AND DEATH approx. 8 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary tuberculosis Far Advanced	
	DUE TO (c) 002X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Atrophy of adrenal cortex		19. WAS AUTOPSY PERFORMED? YES NO <input 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.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 12-3-58 , to 3-31-59 and last saw see him alive on 3-31-59 Death occurred at 2:40 p. m on the date stated above; and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE (Degree or title) C. A. Brasler M.D.	22b. ADDRESS Mt. Vernon, Mo.	22c. DATE SIGNED 4-24-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-2-59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Phoenix, Arizona
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24. FUNERAL DIRECTOR H. D. Fossett, Mt. Vernon, Mo.	25. DATE RECD. BY LOCAL REG. 4-24-59	26. REGISTRAR'S SIGNATURE Cecil Hendricks
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 29 1959

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 *me*....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *H.R. Fossett*.....

Licensed Embalmer No. *2201*.....

P. O. Address *mt. Vernon*.....

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.