

Health, Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017257  
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 110

300  
-57

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WASHINGTON</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>UNION</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. FRANCIS HOSP.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>0367 304 CHURCH ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>ELLEN</b> Last <b>HOLLIDAY</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>1959</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 17, 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOEWORKER</b>	9. AGE (In years last birthday) <b>62</b> IF UNDER 1 YEAR Months <b>7</b> Days <b>21</b> IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>OWENSVILLE, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13a. FATHER'S NAME <b>LAFAYETTE REED</b>		13b. MOTHER'S MAIDEN NAME <b>ALVINE HOLTSCHU</b>	14. NAME OF HUSBAND OR WIFE <b>WM. HOLLIDAY</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>EDGAR HOLLIDAY UNION, MO.</b>

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>Heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Arteriosclerotic Vasculopathy</u>	<u>20 yrs.</u>
	DUE TO (c) <u>Diabetes + aging.</u>	<u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260X</u>		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.	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>21 April 1959</u> to <u>8 May 1959</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>8 May 1959</u> Death occurred at <u>1:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George C. Richardson, M.D.</u>	22b. ADDRESS <u>Union, Mo</u>	22c. DATE SIGNED <u>9 May 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5-11-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CITY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>OWENSVILLE MO.</b>

24. FUNERAL DIRECTOR ADDRESS <u>Wm. Francis Stone Union Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5/11/59</u>	26. REGISTRAR'S SIGNATURE <u>F. J. Stidman, Jr. Stidman</u>
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(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 *Ralph Olthmann* .....

Licensed Embalmer No. *4908* .....  
P. O. Address *Union, 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.