

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 20 1959

59-024131

Registration District No. 38 Primary Registration District No. 2006 Registrar's No. 3108 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Monroe</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>10 Days</b>		c. CITY OR TOWN <b>Monroe City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <del>INSTITUTION</del> <b>Ellis Fischel State Cancer Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Delbert Lee Holliday</b>				4. DATE OF DEATH Month Day Year <b>July 15 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>N</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>July 13, 01</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Monroe City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Del Holliday</b>			13b. MOTHER'S MAIDEN NAME <b>Carrie Scott</b>		14. NAME OF HUSBAND OR WIFE <b>Clara Holliday</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>408-09-3043</b>	17. INFORMANT Address <b>Hospital Records-Highway 40, Columbia</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) <b>Post operative Hemorrhage Following Cystectomy</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Operative Ligation of Ext. Iliac Artery</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) <b>✓ Papillomatosis of Bladder</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> 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.)					
20c. TIME OF INJURY Hour a.m. 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
21. I attended the deceased from <b>July 1st 1957</b> , to <b>July 15th 1959</b> last saw her/him alive on <b>5:49 PM 7/15/59</b> Death occurred at <b>5:50 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Doctor Walter Kaminski, Jr. M.D.</b>				22b. ADDRESS <b>1225 S. Grand Blvd. St. Louis, Mo.</b>		22c. DATE SIGNED <b>7/15/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>7/17/59</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>St. Judes</b>		23d. LOCATION (City, town, or county) <b>Monroe City, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Wilson &amp; Son, Monroe City, Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>July 15 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 23 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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Leslie L. Wilson*

Licensed Embalmer No. 3014

P. O. Address Monroe City

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.