

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025870

FILED JUL 16 1959

Registration District No. 187 Primary Registration District No. 304a Registrar's No. 173

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>15 yrs.</u>		c. CITY OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>104 Jackson</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>104 Jackson</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Middle Last <u>Arvella Blanche Holsman</u>				4. DATE OF DEATH Month Day Year <u>July 6, 1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23/81</u>		9. AGE (last birthday) <u>77</u>		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) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and state or country) <u>Keithsburg, Ill</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13a. FATHER'S NAME <u>John C. Heath</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah E. Wolff</u>				14. NAME OF HUSBAND OR WIFE <u>xx</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>xx</u>		17. INFORMANT Address <u>Mrs. Myrna Shaw, Chillicothe, 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>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension & arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1957</u> , to <u>7-6-59</u> and last saw her ^{per} alive on <u>7-6-59</u> Death occurred at <u>1:40 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Intendant DO</u>						22b. ADDRESS <u>Chillicothe</u>			22c. DATE SIGNED <u>7-7-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE <u>July 9, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Enon cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Carroll Co., Mo.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Donald Gordon, Chillicothe, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>7/7/59</u>		26. REGISTRAR'S SIGNATURE <u>Francis B Neal</u>						

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Arnold Gordon

Licensed Embalmer No. 4191

P. O. Address Chillicothe

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.