

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029726

FILED VS SEP 8 1959

Registration District No. 187 Primary Registration District No. 3240 Registrar's No. 276 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>livingston</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Carroll</b>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Length of stay in 1b <b>11 Months</b>		c. CITY OR TOWN <b>Hale,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Susans Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>Jim Holladay home</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Clinton</b> Last <b>Holladay</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>24th</b> Year <b>1959</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>F</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/29/85</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>25</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>		
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></b>		11. BIRTHPLACE (City and state or country) <b>Tina, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>William Henry Holladay</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Ann Hoover</b>			14. NAME OF HUSBAND OR WIFE <del>James</del> <b>NONE</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>478-12-2967</b>		17. INFORMANT <b>James Holladay</b> Address <b>Hale, Missouri</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>Paralytic Agitation</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b></b> DUE TO (c) <b></b>									
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 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 <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>		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>Aug 9-1958</b> to <b>Aug 24-1959</b> and last saw <sup>her</sup> him alive on <b>Aug 24-59</b> Death occurred at <b>4:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Matthew S.O.</b> (Degree or title)				22b. ADDRESS <b>Chillicothe</b>			22c. DATE SIGNED <b>8-26-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/26, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hale cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Hale, Missouri</b>			
24. FUNERAL DIRECTOR <b>Clifford W. Austin F-H Hale, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>8-26-59</b>		26. REGISTRAR'S SIGNATURE <b>Frances B Kell</b>			

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 \_\_\_\_\_

*Clifford W. Austin*  
Clifford W. Austin,

Licensed Embalmer No. #3233

P. O. Address Tina, Missouri

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.