URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 6 1959

59–035263

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1093

ENDED

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph, Mo
Length of stay in 1b: 4days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: State H ospital #2
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Ray
c. CITY OR TOWN: Elmira
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): none
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Lyndon Middle: J. Last: H olman
4. DATE OF DEATH: Month: TO Day: T9 Year: 59
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: July 25, 1887
9. AGE (last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Grundy County, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Joseph Holman
13b. MOTHER'S MAIDEN NAME: Mary Crowley
14. NAME OF HUSBAND OR WIFE: Beulah Holman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 492-18-5786
17. INFORMANT: H ospital records Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia - Stroke
INTERVAL BETWEEN ONSET AND DEATH: 4-days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Hemorrhage ~~Cerebral Arteriosclrosis~~ Oct 14-1959
DUE TO (c):
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. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 TO-T9-59, to TO-T9-59 and last saw her/him alive on TO-T9-59
Death occurred at 4:35 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C.E. Cassins M.D.
22b. ADDRESS: State Hospital #2
22c. DATE SIGNED: 10-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-19-59
23c. NAME OF CEMETERY OR CREMATORY: Lawson
23d. LOCATION (City, town, or county) (State): Lawson, Missouri

24. FUNERAL DIRECTOR ADDRESS: Jarman Funeral Home, Lawson, mo
25. DATE RECD. BY LOCAL REG.: Oct. 29, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clarke Goodell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

NOV 9 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 m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lindell Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.