

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 1959

59-035844

STATE FILE NUMBER

Registration District No. 228 Primary Registration District No. 2000 Registrar's No. 1158

ENDED

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| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Greene | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield, | Length of stay in 1b 76 years | c. CITY OR TOWN Springfield | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 927 E. Monroe | | d. STREET ADDRESS (If outside, give location) 927 E. Monroe | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First MYRTLE Middle HOLTMAN Last HOLTMAN | | | 4. DATE OF DEATH Month October Day 27, Year 1959 | | | |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH March 13, 1883 | 9. AGE (last birthday) 76 | IF UNDER 1 YEAR Months 7 Days 14 Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY In Home | 11. BIRTHPLACE (City and state or country) Springfield, Missouri | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME Robert Forrester | 13b. MOTHER'S MAIDEN NAME Mary Robinson | 14. NAME OF HUSBAND OR WIFE Harry Holtman |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Mrs. W. B. Shultz Springfield, Mo. |
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| 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>Cardio-vascular disease</u> DUE TO (b) <u>Failure to react to advanced life</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>Second year</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 type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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| 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 type="checkbox"/> |
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| 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 Oct 26 '59 **to** Oct 27 **and last saw her/him alive on** Oct 26 '59
Death occurred at 10:30 **P.** **m on the date stated above, and to the best of my knowledge, from the causes stated.**

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| 22a. SIGNATURE (Degree or title) <u>Don H. Slesby M.D.</u> | 22b. ADDRESS <u>Springfield Mo</u> | 22c. DATE SIGNED <u>10-28-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Oct. 31, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Maple Park | 23d. LOCATION (City, town, or county) (State) Springfield, Missouri |
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| 24. FUNERAL DIRECTOR ADDRESS Gorman-Scharpf Funeral Home Springfield, Missouri | 25. DATE RECD. BY LOCAL REG. <u>10-27-59</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lewis G. Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield

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.