

# FEDERAL BUREAU OF INVESTIGATION

## FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-038624

FILED VS NOV 12 1959

336

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Shannon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>rural</u> Length of stay in 1b <u>6 mo</u> c. FULL NAME OF HOSPITAL OR INSTITUTION <u>at home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u> c. CITY OR TOWN <u>Gladden</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS <u>7 mi South west</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Willard</u> Middle <u>C Holt</u> Last _____ <b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>1</u> Year <u>1959</u>			<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <u>not available</u> <b>8. DATE OF BIRTH</b> <u>10-1-94</u> <b>9. AGE (last birthday)</b> <u>65</u>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired carpenter</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>general</u> <b>11. BIRTHPLACE</b> (City and state or country) <u>But Co Missouri</u> <b>12. CITIZEN OF WHAT COUNTRY</b> <u>U S A</u>		<b>13a. FATHER'S NAME</b> <u>not available</u> <b>13b. MOTHER'S MAIDEN NAME</b> <u>Not available</u> <b>14. NAME OF HUSBAND OR WIFE</b> <u>Not available</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Not available</u> <b>16. SOCIAL SECURITY NO.</b> <u>408 I4 5541</u> <b>17. INFORMANT</b> <u>Mrs Reed</u> Address <u>Gladden Mo</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Causes</u> DUE TO (b) <u>Copper Poison - Shannon Co</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>20g. COUNTY</b> _____		<b>20h. STATE</b> _____			
<b>21. I attended the deceased from _____, to _____, and last saw her/him alive on _____.</b> Death occurred at <u>5 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Mabel Garris Registrar</u>			<b>22b. ADDRESS</b> <u>Shannon Mo</u>		<b>22c. DATE SIGNED</b> <u>11-7-59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>		<b>23b. DATE</b> <u>Nov 7 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Grove</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Dent County Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Spencer Funeral Home Inc</u> ADDRESS _____			<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-7-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mabel Garris</u>		

(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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Carl H. Spinner

Licensed Embalmer No. 2376

P. O. Address Palmyra

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.