

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

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Registration District No. 098 Primary Registration District No. _____ Registrar's No. 19 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rural Union Twp.</u>		Length of stay in lb OR TOWN <u>17 Yrs.</u>		c. CITY OR TOWN <u>Rural Union Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1/2 Mi. East Gallatin</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1/2 Mi. East Gallatin</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Samuel Dockery Holcomb</u>				4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-4-1895</u>		9. AGE (last birthday) <u>64</u>		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) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (City and state or country) <u>Daviess Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Samuel Henry Holcomb</u>				13b. MOTHER'S MAIDEN NAME <u>Eva Lee Whitt</u>				14. NAME OF HUSBAND OR WIFE <u>Opal Holcomb</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>496-42-3417</u>		17. INFORMANT Address <u>Opal Holcomb, Gallatin, Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										<u>3 yrs.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis & Hypertension</u>										<u>10 yrs.</u>			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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 _____, to _____ and last saw her/him alive on <u>did not</u> Death occurred at <u>About 6 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>P. Baumgardner D.D. Coroner</u>				22b. ADDRESS <u>Pattonburg, Mo</u>				22c. DATE SIGNED <u>12/30/59</u> (Sign)					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-3-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>				23d. LOCATION (City, town, or county) <u>Gallatin, Mo.</u>					
24. FUNERAL DIRECTOR <u>J. D. Jackson</u> ADDRESS <u>Hope Funeral Home, Gallatin, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7 Jan. 1960</u>		26. REGISTRAR'S SIGNATURE <u>Dugan W. Engerhart</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 13 1966

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 L. C. Richerson

Licensed Embalmer No. 3307

P. O. Address Fallston

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.