

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS. JAN 20 1960** 340

~~29-1000~~  
STATE FILE NUMBER  
**-59-047087**

Registration District No. \_\_\_\_\_ Primary Registration District No. 6151 Registrar's No. 3

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

3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Lee</b> Last <b>Holloway</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>1959</b>	
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5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</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>1-23-59</b>	9. AGE (last birthday) <b>10</b> Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>child</b>	11. BIRTHPLACE (City and state or country) <b>Parma, Mo. R. 1</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Ezell Holloway</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Lee Collins</b>	14. NAME OF HUSBAND OR WIFE <b>child</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Emma Lee Collins</b> Address <b>Dexter, Mo. R.1</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH HAS BEEN CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pneumonia</b> <b>10 mo.</b>	
	DUE TO (c) <b>Sprue (Pancreatic deficiency)</b> <b>10 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from **December 15, 1959** to **Dec. 18, 1959** and last saw her <sup>her</sup> alive on **Dec. 18, 1959**  
Death occurred at **12-21-59 4:15 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Monnie McComack, D.O.</i> (Degree or title)	22b. ADDRESS <b>Box 482, Bernie, Mo.</b>	22c. DATE SIGNED <b>1/1/60</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>12-23-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dexter Colored Cem.</b>	23d. LOCATION (City, town, or county) <b>Dexter, Mo.</b>
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24. FUNERAL DIRECTOR <b>Watkins &amp; Sons</b> ADDRESS <b>Dexter, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-16-60</b>	26. REGISTRAR'S SIGNATURE <i>Velma V. Jenks</i>
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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 Mark Wathers

Licensed Embalmer No. 4717

P. O. Address Dexter, Mo

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.