URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-005353

FILED VS MAR 1 0 1960

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 74

NDED

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton — Length of stay in 1b: 2 Months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 1 — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howard
c. CITY OR TOWN Glasgow — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First James — Middle — Last Holtzclaw
4. DATE OF DEATH: Month February — Day 28 — Year 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: unknown
9. AGE (last birthday): 80?
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): unknown
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Jerry Holtzclaw
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: State Hospital No. 1 Fulton, Mo. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Right Lower lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Secondary Anemia — Chronic Brain Syndrome
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 State Hospital Dec. 28, 1959 to Feb 28 1960 and last saw him alive on ____
Death occurred at 8:25 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H Jackson (Degree or title) M.D
22b. ADDRESS: Fulton, Missouri
22c. DATE SIGNED: 28 Feb 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2/28/60
23c. NAME OF CEMETERY OR CREMATORY: City Cemetery
23d. LOCATION (City, town, or county) (State): Fayette Mo.

24. FUNERAL DIRECTOR: Ralph A. Carr — ADDRESS: Fayette Mo.
25. DATE RECD. BY LOCAL REG.: March 5. 1960
26. REGISTRAR'S SIGNATURE: Marietta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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