

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026615

FILED VS AUG 8 1960

Registration District No. 133 Primary Registration District No. Registrar's No. 94 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Harrison	
b. CITY (If outside corporate limits, give TOWNSHIP only) GILMAN CITY		c. CITY OR TOWN Gilman City	
c. FULL NAME OF (If NOT in hospital, give location) Home		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) Grace Audrey Holley			4. DATE OF DEATH 8 5 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-9-1888	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Harrison Co. Mo. USA	
13a. FATHER'S NAME John Cotton		13b. MOTHER'S MAIDEN NAME Martha Tucker		14. NAME OF HUSBAND OR WIFE Troy Holley	

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. None	17. INFORMANT Troy Holley	Address Gilman City
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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) Myocardial infarction Chronic Myocarditis Conditions, if any, which gave rise to above cause and stating the underlying cause last. DUE TO (b) Cancer of liver, stomach, pancreas, and pelvis DUE TO (c) Primary Cancer of uterus		INTERVAL BETWEEN ONSET AND DEATH 10 yrs Sept 1959
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 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.)
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 3:15 PM to 5:57 PM on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE B. Bailey	(Degree or title)	22b. ADDRESS Jamesport	22c. DATE SIGNED 8-5-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-7-1960	23c. NAME OF CEMETERY OR CREMATORY Rice Cemetery	23d. LOCATION (City, town, or county) (State) Coffey MO

24. FUNERAL DIRECTOR McKlaas Bethany	ADDRESS Mo.	25. DATE RECD. BY LOCAL REG. August 6-1960	26. REGISTRAR'S SIGNATURE Gella Mayey
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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 _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *W. H. Haer*

Licensed Embalmer No. 3899

P. O. Address Bethany, Mo

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