

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041583

FILED VS NOV 21 1960

Registration District No. 118 Primary Registration District No. 5439 Registrar's No. 34

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gerald, Route 1 Missouri</u>		Length of stay in 1b		c. CITY OR TOWN <u>Gerald Route 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cannan Township</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Cannan Township</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER HIRSH HOLT</u>				4. DATE OF DEATH Month Day Year <u>November 13, 1960</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>July 13, 1881</u>	9. AGE (last birthday) <u>79</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>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Rosebud, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>George Holt</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Boston</u>			14. NAME OF HUSBAND OR WIFE <u>Lizzie Holt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>			16. SOCIAL SECURITY NO. <u>197-05-5886</u>		17. INFORMANT Address <u>Mrs Lizzie Holt, Gerald, Mo. RI</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myelocytic Leukemia</u> DUE TO (b) <u>Cause Undetermined</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 checked="" 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 <u>1936</u> to <u>11/13/60</u> and last saw her alive on <u>11/2/60</u> Death occurred at <u>11:10 P.M.</u> on the date stated above and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>James A Shea MD</u> (Degree or title)				22b. ADDRESS <u>Gerald Mo</u>		22c. DATE SIGNED <u>11/14/60</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 16, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bouuff Presbyterian</u>			23d. LOCATION (City, town, or county) (State) <u>Gerald, Franklin, Mo.</u>				
24. FUNERAL DIRECTOR <u>Oltmann Funeral Home, Gerald, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>November 16, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Marjorie Japprey</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 21 1960

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 Ernest L. Altman

Licensed Embalmer No. 4057

P. O. Address Union

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