

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045490

FILED VS. JAN 6 1961 75

Registration District No. _____ Primary Registration District No. 3015 Registrar's No. 135

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY Clinton				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Clinton									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cameron		Length of stay in 1b 8 Mons.		c. CITY OR TOWN Cameron		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 115 1/2 West Third St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 115 1/2 West Third St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Thomas Middle Harper Last Hollingsworth				4. DATE OF DEATH Month 12 Day 25 Year 60									
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1899	9. AGE (last birthday) 71	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) Nite Clerk			10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (City and state or country) Mercer Co. Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.						
13a. FATHER'S NAME Hollingsworth Wm. A. Hollingsworth			13b. MOTHER'S MAIDEN NAME Mary E. Bruce			14. NAME OF HUSBAND OR WIFE Adaline Hollingsworth							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 513-20-3707		17. INFORMANT Adaline Hollingsworth Address Cameron Mo.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery infarction DUE TO (b) Coronary artery occlusion DUE TO (c) Coronary arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 15 min 15 min 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bilateral - Pulmonary Tuberculosis						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 4-25-59 to 12-25-60 and last saw ^{her} _{him} alive on 12-25-60 Death occurred at 7:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22. SIGNATURE (Degree or title) F. H. Compton						22b. ADDRESS Cameron, Mo.			22c. DATE SIGNED 12-27-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-27-60	23c. NAME OF CEMETERY OR CREMATORY Wood Cemetery			23d. LOCATION (City, town, or county) (State) Maysville Mo.							
24. FUNERAL DIRECTOR Poland Funeral Home ADDRESS Cameron Mo.				25. DATE RECD. BY LOCAL REG. 12-27-60		26. REGISTRAR'S SIGNATURE Francis D Crawford							

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert F. Colaneri

Licensed Embalmer No. 477
308 West
P. O. Address Cameron

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.