# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS FEB 6 1961

-61-000530
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 44

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF |
|---|---|---|---|---|
| | | | | |

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Cape Girardeau — Length of stay in 1b: 7 Days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): S.E. Mo Hosp. — Inside Limits: Yes ☒ No ☐

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

3. NAME OF DECEASED (Type or print): First CLAUDE Middle Last HOLLINGER
4. DATE OF DEATH: Month Jan Day 30 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Sept 13, 1891
9. AGE (last birthday): 69 — 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): Rail Road Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Rail Road
11. BIRTHPLACE (City and state or country): Carmi, Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John Hollinger
13b. MOTHER'S MAIDEN NAME: Nancy R. Dugan
14. NAME OF HUSBAND OR WIFE: Ada Robertson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Ada Hollinger Address: Illmo, Mo

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): Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cirrhosis of liver
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 12-27-60 to 1/30/60 and last saw her/him alive on 1/30/60
Death occurred at 2:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J Marshall Jung M.D. (Degree or title)
22b. ADDRESS: Illmo Mo
22c. DATE SIGNED: 1-31-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb 2, 1961
23c. NAME OF CEMETERY OR CREMATORY: Linwood Cemetery
23d. LOCATION (City, town, or county) (State): Paragould, Arkansas

24. FUNERAL DIRECTOR: BISPLINGHOFF FUNERAL HOME ADDRESS: Illmo, Mo
25. DATE RECD. BY LOCAL REG.: 2-1-61
26. REGISTRAR'S SIGNATURE: Irene Kasten

(Licensed Embalmer's Statement on Reverse Side)

APR 3 1967

FEB 15 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Oliver C Smith

Licensed Embalmer No. 4470

P. O. Address Salem, 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.