ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-007458
STATE FILE NUMBER

AMENDED

Registration District No. 002 Primary Registration District No. 4009 Registrar's No. 13

FILED VS MAR 16 1961

1. PLACE OF DEATH a. COUNTY Andrew

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Savannah — Length of stay in 1b: 5 yrs.

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 615 West Pearl — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew

c. CITY OR TOWN Savannah — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 615 West Pearl — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Charles Middle: Brewer Last: Holder

4. DATE OF DEATH Month, Day, Year: March 3, 1961

5. SEX: male

6. COLOR OR RACE: white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2-13-79

9. AGE (last birthday): 82

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): retired farmer

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (City and state or country): Confidence, Iowa

12. CITIZEN OF WHAT COUNTRY: U S A

13a. FATHER'S NAME: James Holder

13b. MOTHER'S MAIDEN NAME: unk

14. NAME OF HUSBAND OR WIFE: Ella Holder

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 Address: Mrs. Ella Holder, Savannah, 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) Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Hypertension — 2 years

DUE TO (c)

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. ☐ 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 11-6-58, to 3-3-61 and last saw ~~him~~ him alive on 3-3-61

Death occurred at 7:00 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Gilbert B. Kellogg MD

22b. ADDRESS: Savannah, Missouri

22c. DATE SIGNED: 3-6-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: 3-5-61

23c. NAME OF CEMETERY OR CREMATORY: Savannah Cemetery

23d. LOCATION (City, town, or county) (State): Savannah, Missouri

24. FUNERAL DIRECTOR: Breit & Hawkins ADDRESS: Savannah

25. DATE RECD. BY LOCAL REG.: 3-9-61

26. REGISTRAR'S SIGNATURE: L Spark

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF | DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.