

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-036573

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1028

FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Webster	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield, Missouri		Length of stay in 1b 5 days	c. CITY OR TOWN Marshfield, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DRS' MEMORIAL OSTEOPATHIC		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 314 W. Second St. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mary Middle L Last Holloway	4. DATE OF DEATH Month Oct. Day 26, Year 1961
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1880	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Webster County, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME W. R. Holloway	13b. MOTHER'S MAIDEN NAME Sara Nelson	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT Robert Holloway - Rt. 1; Strafford, Mo.	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Inanition and Debilitation.		Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Carcinomatosis.	Unknown
	DUE TO (c) Carcinoma of Rectum.	Unknown

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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 Springfield, Mo.	COUNTY Webster	STATE Mo.
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21. I attended the deceased from **10-21-61** to **10-26-61** and last saw her/him alive on **10-26-61**
Death occurred at **10-26-61** **1:00** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dee or title) <i>Eland E. Wetzel</i>	22b. ADDRESS D.O., 700 E. Sunshine; Springfield, Mo.	22c. DATE SIGNED 10-26-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-26-1961	23c. NAME OF CEMETERY OR CREMATORY MT. PISGAH	23d. LOCATION (City, town, or county) (State) WEBSTER CO Mo.
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24. FUNERAL DIRECTOR Barber-Edwards F.H.	ADDRESS Marshfield, Mo.	25. DATE RECD. BY LOCAL REG. 10-30-61	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>
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DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

NOV 28 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 *[Handwritten Signature]*

Licensed Embalmer No. 3848

P. O. Address *[Handwritten Address]*

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.