

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **248-61-028081**

Registration District No. **390** Primary Registration District No. **4442** Registrar's No. _____

AMENDED

FILED NOV 2 1961

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Higbee		Length of stay in lb years years	c. CITY OR TOWN Higbee Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Elmira Middle Melissa Last Holtzclaw			4. DATE OF DEATH Month 10 Day 22 Year 61		
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5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/4/75	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state of country) Morgan Co., Ohio	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME W.C. Shook	13b. MOTHER'S MAIDEN NAME Mary LeFever	14. NAME OF HUSBAND OR WIFE T.A. Holtzclaw
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Jack Holtzclaw Address Higbee, Mo.
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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: IMMEDIATE CAUSE (a) Cerebral Vascular accident		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral arterio-sclerosis	
	DUE TO (c) General arterio-sclerosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerotic heart disease	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
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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.) Relatively sudden Terminating C.V.A.
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20c. TIME OF INJURY 10-19-61 Hour 10 a.m. Month, Day, Year
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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.) Home	20f. CITY, TOWN, OR LOCATION Higbee COUNTY Randolph STATE Missouri
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21. I attended the deceased from **7-14-61** to **10-22-61** and last saw her/him alive on **10-22-61**
Death occurred at **5PM** **10-22-61** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. G. Richmond D.O. (Degree or title)	22b. ADDRESS Higbee Mo	22c. DATE SIGNED 10/26/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/24/61	23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery	23d. LOCATION (City, town, or county) S. of Higbee, Mo. (State)
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24. FUNERAL DIRECTOR Marion E. Million ADDRESS Moberly, Mo.	25. DATE RECD. BY LOCAL REG. 10/24/61	26. REGISTRAR'S SIGNATURE Leabelloue
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DATE AMENDED _____
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS _____
 INSTEAD OF _____
 DOCUMENT _____
 MEDICAL CERTIFICATION _____
 SHOULD READ _____
 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 by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Erma M. Million

Licensed Embalmer No. 3956

P. O. Address Moberly, 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.