

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10963** STATE FILE NUMBER **61-042523**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis</b>		c. CITY OR TOWN <b>ST. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Stone Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>2626 S. Kingshighway</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Holdenried</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1913</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ph</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Profession</b>		11. BIRTHPLACE (City and state of country) <b>ST. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Philip Holdenried</b>		13b. MOTHER'S MAIDEN NAME <b>Barbara Michel</b>	
14. NAME OF HUSBAND OR WIFE <b>Emmy J. M. Holdenried</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Laura Krause</b>		Address <b>2626 S. Kingshighway</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		
			DUE TO (c) <b>331x</b>		

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 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 **Jan 1961**, to **11-23-61** and last saw him <sup>alive</sup> on **11-19-61**  
 Death occurred at **10:30 pm** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W. J. Squald M.D.</b> (Degree or title)	22b. ADDRESS <b>3915 WATSON RD.</b>	22c. DATE SIGNED <b>11/24/61</b>
--------------------------------------------------------------	----------------------------------------	-------------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 25, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Mausoleum</b>	23d. LOCATION (City, town, or county) (State) <b>ST. Louis Co, Mo.</b>
------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Witt Bros. Mortuary</b>	ADDRESS <b>6409 Gravois</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 25 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>
----------------------------------------------------	--------------------------------	----------------------------------------------------	------------------------------------------------------

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 by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kable

Licensed Embalmer No. 4596  
P. O. Address St Louis, 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.