

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-62-011799**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 181 Primary Registration District No. 4294 Registrar's No. 11

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAR 27 1962**

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lincoln</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Silex RFD #1</b>		Length of stay in lb <b>Life</b>	c. CITY OR TOWN <b>Silex RFD #1</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ninevah Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Ninevah Township</b>
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Marie</b> Last <b>Holt</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1962</b>	

5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-29</b>	9. AGE (last birthday) <b>33</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b>	IF UNDER 24 HR Hours <b>16</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>Lincoln Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>US</b>
13a. FATHER'S NAME <b>Joseph Shramek</b>	13b. MOTHER'S MAIDEN NAME <b>Marie Puchta</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Holt</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>Frank Holt RFD #1 Silex, Mo.</b>	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 <b>16 hours</b>
IMMEDIATE CAUSE (a) <b>Acute Febrile Illness</b>		
DUE TO (b) <b>Cause unknown</b>		
DUE TO (c) <b>Natural Cause</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 checked="" 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.)	
20c. TIME OF INJURY Hour <b>6:30 A</b> a.m. p.m.	Month, Day, Year <b>3-22-62</b>		
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.)	20f. CITY, TOWN, OR LOCATION <b>Silex Mo.</b>	COUNTY <b>Lincoln</b> STATE <b>Mo.</b>

21. I attended the deceased from **3-22-62** to **3-23-62** and last saw her alive on **3-23-62**  
Death occurred at **6:30 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>R.M. Penn - M.D.</b>	22b. ADDRESS <b>Silex Mo.</b>	22c. DATE SIGNED <b>3-24-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-26-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus Cem.</b>	23d. LOCATION (City, town, or county) <b>Millwood, Missouri</b>
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24. FUNERAL DIRECTOR <b>J. O. Mudd</b>	ADDRESS <b>Bowling Green, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-26-62</b>	26. REGISTRAR'S SIGNATURE <b>Ray F. Plasel</b>
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(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59  
  
10570  
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7 0  
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97888E  
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133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

*Acting Local Reg. by R.F.*

Permit Renewal 3-26-62

**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 O. Mudd

Licensed Embalmer No. 4152

P. O. Address Beaulieu Farm, 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.