

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 70 STATE FILE NUMBER 62-043832

FILED DEC 10 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
0930		
2930		
3		
4 1		
5 2		
6		
7 0		
8 0		
94201		
10		
11		
1290-8		
132-0		
	INSTEAD OF	
	DOCUMENT	
	MEDICAL CERTIFICATION	
	BY AFFIDAVIT OF	
	SHOULD READ	
	ITEM NO.	

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Length of stay in 1b <u>Years</u>	c. CITY OR TOWN <u>Osceola</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>in home</u>		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 <u>Ida</u> Middle <u>J.</u> Last <u>Holladay</u>			4. DATE OF DEATH Month <u>Nov</u> ; Day <u>16</u> , Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/85</u>
9. AGE (last birthday) <u>77</u>		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) <u>housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Clair County Mo. USA</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>Sam Howerton</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Alexander</u>
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT <u>Pauline Myers, Osceola Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apparently myocardial infarction</u> DUE TO (b) <u>infarction</u> DUE TO (c) <u>found dead in bed</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>no known medical care.</u>			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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on <u>11-20-1962</u> Death occurred at <u>12:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ruth Seewers Local Reg.</u>		22b. ADDRESS <u>Osceola Missouri</u>	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/18/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>	23d. LOCATION (City, town, or county) (State) <u>Osceola Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Goodrich Funeral Home, Osceola Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-1962</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>

APR 2 1963

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 Paul J. [Signature]

Licensed Embalmer No. 3990

P. O. Address Osceola 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.