

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 0040118 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0425
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Edwards</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Missouri b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Length of stay in 1b <u>5/14/1964</u>	c. CITY OR TOWN <u>Clinton</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wentzel Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>308 N Second St</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONA CORDELL HOLCOMB</u>			4. DATE OF DEATH Month Day Year <u>Oct 28 1964</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper of Smith Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Calhoun Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
13a. FATHER'S NAME <u>Geo. W Holcomb</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Knox</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>490-05-8065</u>		17. INFORMANT Address <u>Helin Epple Clinton Mo</u>	
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>Congestive circulatory failure</u> DUE TO (b) <u>Thrombotic encephalomalacia of prolonged recumbency</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebrovascular accident - hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH
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 <u>July, 1954</u> to <u>Oct. 28, 1964</u> and last saw her/him alive on <u>Oct. 27, 1964</u> Death occurred at <u>4:00 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>R. E. Harbaugh, M.D.</u>		22b. ADDRESS <u>Clinton Mo.</u>	22c. DATE SIGNED <u>10-30-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u>	23b. DATE <u>10/30/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALHOUN</u>	23d. LOCATION (City, town, or county) (State) <u>CALHOUN MO.</u>
24. FUNERAL DIRECTOR <u>F. L. SCHABERG CLINTON, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT. 31, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

2491

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

MISSOURI STATE BOARD OF HEALTH

NOV 30 1964

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 F. L. Schaub

Licensed Embalmer No. 4513

P. O. Address Clinton 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.