

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040339

10192

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10192

1. PLACE OF DEATH a. COUNTY ST. LOUIS		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 6 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. FRANCOIS		c. CITY OR TOWN FARMINGTON		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) ROUTE #3				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLARD H. HOLMES			4. DATE OF DEATH Month Day Year 10/23/62			5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 10/14/04		9. AGE (last birthday) 58		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) FARMER			
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) MADISON COUNTY, MISSOURI, U.S.A.				12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME CYRUS HOLMES				13b. MOTHER'S MAIDEN NAME CORA JOHNSON				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) YES WW-II				16. SOCIAL SECURITY NO. 498-26-7265		17. INFORMANT Address CORA HOLMES (MOTHER) SEE #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA. DUE TO (b) ACUTE AND CHRONIC PYELONEPHRITIS DUE TO (c) 600.0 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)								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 checked="" type="checkbox"/> NO <input 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 s.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. <input checked="" type="checkbox"/> attended the deceased from 10/17/62 to 10/23/62 and last saw him alive on 10/23/62 Death occurred at 12:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) JOSEPH P. SCHAEFER M.D.						22b. ADDRESS VAH, ST. LOUIS, MO.			22c. DATE SIGNED 10/23/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-26-62		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Farmington, Mo.		(State)			
24. FUNERAL DIRECTOR ADDRESS Cozean Funeral Home, Farmington, Mo.						25. DATE RECD. BY LOCAL REG. OCT 24 1962		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

83

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.