FILED JUN 30 1970

DEPARTMENT OF PUBLIC HEALTH AND WELFARE – MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

# CERTIFICATE OF DEATH

124

STATE FILE NUMBER 70 0025394

DO NOT WRITE ON THIS STUB

VS 300 Rev. 1/70

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 297

| | |
|---|---|
| 9. | 0 |
| 10a. | 72 |
| 10b. | |
| 11. | 0 |
| 12. | 1 |
| 13. | 4123 |
| 14. | |
| 15. | 4 |
| 16. | |
| 17. | |
| 18. | 0 |
| 19. | CREDITS |
| 20. | 1—0 |

4. 0941
5. 01
6. 1100

**DECEASED**

1. DECEASED—NAME: Amos Franklin Holdman
2. SEX: Male
3. DATE OF DEATH (MONTH, DAY, YEAR): June 20, 1970
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.) (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 72
5b. UNDER 1 YEAR: MOS. / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (MONTH, DAY, YEAR): January 22, 1898
7a. COUNTY OF DEATH: St. Francois
7b. CITY, TOWN, OR LOCATION OF DEATH: Bonne Terre
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): yes
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): Bonne Terre Hosp. Bonne Terre, Mo
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Mo
9. CITIZEN OF WHAT COUNTRY: U.S.A
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Married
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME): Burcham, Irene Holdman
12. SOCIAL SECURITY NUMBER: 493-03-9271
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Lead Miner
13b. KIND OF BUSINESS OR INDUSTRY: Lead Miner

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

14a. RESIDENCE—STATE: Mo
14b. COUNTY: Washington
14c. CITY, TOWN, OR LOCATION: Caledonia
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): No
14e. STREET AND NUMBER: RFD 1 Caledonia

**PARENTS**

15. FATHER—NAME (FIRST MIDDLE LAST): Thomas R. Holdman
16. MOTHER—MAIDEN NAME (FIRST MIDDLE LAST): Blackwell, Laura Holdman

17a. INFORMANT—NAME: Mrs. Irene Holdman
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): RFD 1 Caledonia, Mo

**CAUSE**

PART I. DEATH WAS CAUSED BY: [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]

18. IMMEDIATE CAUSE
(a) Left Ventricular Failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Arterio-Sclerotic—Heart Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c)

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (b)

19a. AUTOPSY (YES OR NO): No
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH

20a. ACCIDENT, SUICIDE, HOMICIDE OR UNDETERMINED (SPECIFY)
20b. DATE OF INJURY (MONTH, DAY, YEAR)
20c. HOUR
20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)
20e. INJURY AT WORK (SPECIFY YES OR NO)
20f. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY)
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)
20h. IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS ☐ YES ☐ NO ☐ UNK

**CERTIFIER**

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM 11-15-69 (MONTH DAY YEAR)
21b. TO 6-21-70 (MONTH DAY YEAR)
21c. AND LAST SAW HIM/HER ALIVE ON 6-20-70 (MONTH DAY YEAR)
21d. DID/DID NOT VIEW THE BODY AFTER DEATH. NO
21e. DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED. 1:30 A (HOUR)

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. HOUR OF DEATH
22b. THE DECEDENT WAS PRONOUNCED DEAD MONTH DAY YEAR HOUR

23a. CERTIFIER—NAME (TYPE OR PRINT): C. H. Appleberry, M.D.
23b. SIGNATURE: C. H. Appleberry DEGREE OR TITLE: MD
23c. DATE SIGNED (MONTH, DAY, YEAR): 6-23-70
23d. MAILING ADDRESS—CERTIFIER: STREET OR R.F.D. NO.: 43 St. Joe CITY OR TOWN: Rivermines STATE: Mo. ZIP: 63601

**BURIAL**

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
24b. CEMETERY OR CREMATORY—NAME: Parkview Cem
24c. LOCATION CITY OR TOWN STATE: Near Farmington, Mo
24d. DATE (MONTH, DAY, YEAR): June 23, 1970
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Caldwell Funeral Home 711 E. Main, Flat River, Mo
25b. FUNERAL DIRECTOR—SIGNATURE: David P. Caldwell
26a. REGISTRAR—SIGNATURE: Esther Matthews
26b. DATE RECEIVED BY LOCAL REGISTRAR: June 23, 1970

Type or print in PERMANENT BLACK INK. See handbook for instructions.

JUL 2 1970

**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 David P. Caldwell

Licensed Embalmer No. 5184

P. O. Address Flat River, 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.