

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. FERRELL

State File No. **36520**

FILED DEC 5 1955

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1068**

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|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE MISSOURI | | b. COUNTY HOWELL | |
| b. CITY (If outside corporate limits, write RURAL and give township) SPRINGFIELD | | c. CITY OR TOWN MT. VIEW | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. LENGTH OF STAY (In this place) 2 WEEKS | | e. STREET ADDRESS (If rural, give location) 0461 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSP. | | | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) FRED | | | b. (Middle) M. | | | c. (Last) BUCHHOLZ JR. | | | 4. DATE OF DEATH (Month) (Day) (Year) NOV. 25 1955 | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | | 8. DATE OF BIRTH OCT. 1 1891 | | 9. AGE (In years last birthday) 64 | | IF UNDER 1 YEAR Months Days 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 FARM. | | 11. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILL. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |

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| 13a. FATHER'S NAME FRED M. BUCHHOLZ | | | 13b. MOTHER'S MAIDEN NAME TERESE DUESSING | | | 14. NAME OF HUSBAND OR WIFE X | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO | | | 16. SOCIAL SECURITY NO. NO | | | 17. INFORMANT'S SIGNATURE OR NAME MRS. ANNA G. KIRK | | | ADDRESS MT. VIEW, MO. | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <p>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</p> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | Adeno-Carcinoma of Pancreas | | | | | | 157X | |
| | | ANTECEDENT CAUSES | | metastatic to liver, stomach and duodenum | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS | | Abdominal distention, jaundice | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Metastatic Adeno-Carcinoma of Pancreas, stomach | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |

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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from **Nov. 9, 1955**, to **Nov. 25, 1955**, that I last saw the deceased alive on **Nov. 9, 1955**, and that death occurred at **1:40 A.M.** from the causes and on the date stated above.

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| 23a. SIGNATURE G. B. Ferrell | | (Degree or title) M.D. | | 23b. ADDRESS Springfield, Missouri | | 23c. DATE SIGNED 11-26-55 | |
|--|--|----------------------------------|--|--|--|-------------------------------------|--|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 24b. DATE 11/25/55 | | 24c. NAME OF CEMETERY OR CREMATORY | | 24d. LOCATION (City, town, or county) (State) MT. VIEW, MO. | |
| DATE REC'D BY LOCAL REG. 11-28-55 | | REGISTRAR'S SIGNATURE Edith Williamson | | 25. FUNERAL DIRECTOR'S SIGNATURE B. W. ... | | ADDRESS SPRINGFIELD, MO. | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Lucien T. Swall*.....

Licensed Embalmer No. *18*.....

P. O. Address *Chicago*.....

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.