

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016623
STATE FILE NUMBER

FILED MAY 25 1959 Registration District No. 002 Primary Registration District No. _____ Registrar's No. 30

1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lincoln Township		c. CITY OR TOWN Amazonia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 4 miles NW	

3. NAME OF DECEASED First Middle Last
MARGARET ANN HOLLENBECK

4. DATE OF DEATH Month Day Year
May 11 1959

5. SEX **female** 6. COLOR OR RACE **white** 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH **May 13, 1872** 9. AGE (In years last birthday) **86**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife** 10b. KIND OF BUSINESS OR INDUSTRY **at home** 11. BIRTHPLACE (City and state or country) **Amazonia, Missouri** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Mack McCush** 13b. MOTHER'S MAIDEN NAME **UNK** 14. NAME OF HUSBAND OR WIFE **UNK**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **—** 17. INFORMANT Address **William Hollenbach, RFD #1, Amazonia**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Myocardial Infarction**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **Coronary occlusion**
DUE TO (c) **Coronary Sclerosis**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **4201**

INTERVAL BETWEEN ONSET AND DEATH **48 hrs.**
48 hrs.
approx 5 years

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Death occurred at **6-24-55** to **5-11-59** and last saw ^{xxx}him alive on **5-6-59**
1:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **William B. Kelley MD** 22b. ADDRESS **Savannah, Missouri** 22c. DATE SIGNED **5-12-59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **burial** 23b. DATE **5/13/59** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Olivet Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Joseph, Missouri**

24. FUNERAL DIRECTOR ADDRESS **Breit Funeral Home, Savannah** 25. DATE RECD. BY LOCAL REG. **5-43-59** 26. REGISTRAR'S SIGNATURE **Kelley & Sparks**

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James B. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *Savannah*

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.