

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-039175

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 155 Primary Registration District No. 5579 Registrar's No. 195

FILED NOV 1 1962

VS 300  
Rev. 4/59

10490  
20600

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jasper</u>		a. STATE <u>Missouri</u> b. COUNTY <u>McDONALD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NEED CITY MINERAL</u> Length of stay in 1b <u>2 MONTHS</u>		c. CITY OR TOWN <u>Goodman</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ELM HURST REST HOME</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Noah Levi HOLLAWAY</u>			4. DATE OF DEATH Month Day Year <u>OCT. 16 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-1893</u>
9. AGE (last birthday) <u>69</u>		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) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>WAYNE COUNTY, ILL.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John W. HOLLAWAY</u>	
13b. MOTHER'S MAIDEN NAME <u>Charlotte Howard</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Bert Hollaway Goodman, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH (Under Part I) <u>48 hrs.</u>
IMMEDIATE CAUSE (a) <u>Pneumonia Bil</u>			
DUE TO (b) <u>Cerebral Pneumonia</u>			
DUE TO (c) <u>1 year</u>			
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 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 Month, Day, Year a.m. p.m.			
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>Aug. 29, 1962</u> to <u>Oct. 3, 1962</u> and last saw <u>him</u> live on <u>Oct. 3, 1962</u>		Death occurred at <u>5:25 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Levin Anderson M.D.</u>		22b. ADDRESS <u>201 Medical Arts, Joplin, Mo.</u>	22c. DATE SIGNED <u>10/27/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 19, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anderson</u>	23d. LOCATION (City, town, or county) (State) <u>Anderson, Mo.</u>
24. FUNERAL DIRECTOR <u>Rehler Funeral Home Goodman, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-30-62</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Shitzer</u>

USE BLACK INK OR TYPEWRITER RIBBON

Removal permit received 10-16-62

**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.

\_\_\_\_\_  
Signature of Student Embalmer

Signed Robert C. Roller

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.