WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25363

PLACE OF DEATH

County: Adair

Township: _____ or Village: _____ or City: Kirksville (NO. 807 E. Illinois St.; 1st Ward)

Registration District No. 4 — File No. _____

Primary Registration District No. 3001 — Registered No. 91

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Charlotte Holloway

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Oct. (Month) 15 (Day), 1839 (Year)

AGE: 73 yrs. 10 mos. 17 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 9 - 0

BIRTHPLACE (City or town, State or foreign country): Marion Co. Mo

PARENTS

NAME OF FATHER: Bradford Hunsaker

BIRTHPLACE OF FATHER (City or town, State or foreign country): Illinois

MAIDEN NAME OF MOTHER: Susan Dicy Stice

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): W. R. Holloway

(ADDRESS): Kirksville, Mo.

Filed Aug 29, 1913. A W Parrish, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: August (Month) 28 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 15, 1913, to Aug 28, 1913, that I last saw her alive on Aug 19, 1913, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
131
9 [illegible]

(Duration) 5 yrs. ___ mos. ___ ds.

Contributory (SECONDARY): Valvular heart disease

(Duration) 2 yrs. ___ mos. ___ ds.

(Signed) E. C. Grim M. D.

8/28, 1913 (Address) Kirksville Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Cater Memorial Cemetery

DATE OF BURIAL: Aug 29, 1913

UNDERTAKER: E. G. Swigert

ADDRESS: Kirksville Mo.

Revised United States Standard Certificate of Death

MISSOURI STATE BOARD OF I
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

PLACE OF DEATH

County Adair

Township Benton

or

Village

or

City Kirksville (NO. St.; Ward)

Registration District No. File No.

Primary Registration District No. Registered No.

[If de hospita give it of stre

FULL NAME Charlotte Holloway

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	

DATE OF BIRTH Oct (Month) 15 (Day), 1839 (Year)

AGE 75 yrs. 10 mos. 17 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) [illegible]

PARENTS

NAME OF FATHER Bradford Thousaker

BIRTHPLACE OF FATHER (City or town, State or foreign country) Illinois

MAIDEN NAME OF MOTHER Susan Dingstice

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Knox

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Holloway

(ADDRESS) Kirksville Mo

Filed ___, 191__, ___

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ___ (Month) (

I HEREBY CERTIFY, that I attended ___, 191__, to ___ that I last saw h___ alive on ___ and that death occurred, on the date stated above

The CAUSE OF DEATH* was as follows:

___ (Duration) ___ yrs.

Contributory (SECONDARY) ___ (Duration) ___ yrs.

(Signed) ___

___, 191__ (Address) ___

*State the Disease Causing Death, or, in deaths from V (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homi

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE O
UNDERTAKER	ADDRE