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

Do not use this space.

1176

File No. 223

Registered No. 223

1. PLACE OF DEATH

County: Jackson — Registration District No. 3 2 3

Township: Fan — Primary Registration District No. 2

City: K.C. Mo (No. ..... City or Town ..... St. ..... Ward)

2. FULL NAME: Will Hollinsworth

(a) Residence. No. 1623 Olive St., ... Ward. (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. If ~~MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~: Rose Hollinsworth

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 27 1876

7. AGE: Years: 50 — Months: 11 — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

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

(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Texas

PARENTS

10. NAME OF FATHER: Ho Hollinsworth

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT: Rosa Hollinsworth

(Address): 1623 Olive St

15. FILED: Jan 17 1927 — M. M. Crowe, Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 13 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1927, to Jan 13, 1927, that I last saw him alive on Jan 13, 1927, and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

GPA (apoplexy) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ..... DID AN OPERATION PRECEDE DEATH? ..... DATE OF ..... WAS THERE AN AUTOPSY? no WHAT TEST CONFIRMED DIAGNOSIS? Clinical

1/13/27 (Signed) [illegible], M. D. (Address) 810 Cudahy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Blue Ridge Comm — DATE OF BURIAL: 1-17 1927

20. UNDERTAKER: [illegible] — ADDRESS: City

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.

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