JAN 28 1929

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

Do not use this space.
2931

1. PLACE OF DEATH

County: Pike
Township: Salem
City: Clarksville R.F.D. (No. ..., ..., St. ..., Ward)

Registration District No. 68
Primary Registration District No. 9969 a

File No.
Registered No.

2. FULL NAME Nancy May Holliday

(a) Residence. No. ... 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. 1 mos. 28 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fem	Black	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7-28

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) R.F.D. Clarksville
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Silas Holliday
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pike Co
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Sarah Jane Dorsey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pike
(STATE OR COUNTRY) Mo

14. INFORMANT Silas Holliday
(Address) R.F.D. Clarksville Mo

15. FILED Jan 4th 1929 Bettie Durrell Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Jan 4, 1929, that I last saw he alive on Jan 3, 1929, and that death occurred, on the date stated above, at 8:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchio pneumonia
10 hrs

(duration) ... yrs. ... mos. 1 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical diagnosis
(Signed) Chas. B. Ashbrook, M. D.
, 19 (Address) Paynesville Mo

*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 Ferris grove
DATE OF BURIAL Jan 5th 1929

20. UNDERTAKER Fred Chapman
ADDRESS Louisiana Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months, days, or hours, as may be most exact. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements are important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Pike — Registration District No. 681 — File No. .....
Township Calumet — Primary Registration District No. 5909 a — Registered No. .....
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Nancy May Holliday
(a) Residence. No. ..... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Col	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Jan 4th 1929 Bettie Duvall Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
..... (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? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. ... should be carefully supplied. AGE should ... EXACTLY. PHYSICIANS should state CAUS... in terms, so that it may be properly classified. Ex... of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-2931