NOV 28 1930

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

Do not use this space.

31910

1. PLACE OF DEATH

County: Texas — Registration District No. 1027 — File No.

Township: Polk — Primary Registration District No. 6196 — Registered No.

City: Mountain Grove (No. ..., ..., St. ..., Ward)

2. FULL NAME: Mrs Dora Holland

(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: Female

4. COLOR OR RACE: White

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John H. Holland

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

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	1	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: 0

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

PARENTS

10. NAME OF FATHER: James Mallonee

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ...
(STATE OR COUNTRY): Tennessee

12. MAIDEN NAME OF MOTHER: Winnie Hale

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ...
(STATE OR COUNTRY): Missouri

14. INFORMANT: John H. Holland
(Address): Mountain Grove

15. FILED Nov. 8, 1930 J. Dwight Thomas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9 - 1 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to 9/1, 1930, that I last saw h. alive on ..., 19..., and that death occurred, on the date stated above, at 5:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Stomach

4 to 5 (duration) 2 yrs. ... mos. ... ds.

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

18. WHERE WAS DISEASE CONTRACTED: Home

IF NOT AT PLACE OF DEATH? ...

DID AN OPERATION PRECEDE DEATH? no DATE OF ...

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic

(Signed) W. H. Hubbard, M. D.

9/2, 1930 (Address) Mtn Grove 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: Stubs Cemetery — DATE OF BURIAL: 9 1 3 1930

20. UNDERTAKER: Dallow Funeral Home — ADDRESS: Mtn Grove Mo

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 UNFADING INK. THIS CERTIFICATE MUST BE FILED WITHIN TEN DAYS AFTER DEATH.

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: Texas Registration District No.: 1027 File No.:
Township: Clinton Primary Registration District No.: 6126 Registered No.:
City: (No. , St. Ward)

2. FULL NAME: Disa Holland

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 5 6 8

7. AGE: Years 62 | Months 1 | Days 29 | 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 Oct 1, 19 30 J. D. Weatherman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9 - 1 - 19 30

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 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:

(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

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 be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

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