

NOV 21 1930

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

Do not use this space.

32094

File No. _____
Registered No. 202
St. _____ Ward)

1. PLACE OF DEATH

County Boone Registration District No. 73
Township _____ Primary Registration District No. 3006
City Columbia Mo (No. _____) St. _____ Ward)

2. FULL NAME Luther Holloway

(a) Residence No. 309 Ash St 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)

Male White Married

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

Mrs Catherine D. Holloway

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 26 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 1 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Saline Co
(STATE OR COUNTRY)

10. NAME OF FATHER Henry Holloway

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

12. MAIDEN NAME OF MOTHER Alice Hopper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

14. INFORMANT Mrs Arvil Platt
(Address) Columbia, Mo

15. FILED 10/3/30 F. C. Suggatt
By Seldy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 2nd 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 to Oct 3 1930
that I last saw him alive on Oct 2 1930, and that death occurred, on the date stated above, at 8:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
9 2 A

(duration) 4 yrs. - mos. - ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? J. B. Ford sputum 309
(Signed) W. K. Schmidt M. D.

10/2, 1930 (Address) Columbia, 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

DATE OF BURIAL

New Salem

Oct 4 1930

20. UNDERTAKER

ADDRESS

F. W. Wier

Columbia

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.

