

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

Do not use this space.

37205

**1. PLACE OF DEATH**

County Missouri Registration District No. 526  
 Township St. Louis Primary Registration District No. 5762  
 City Charleston (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mark Andrew Hollins  
 (a) Residence, No. R30 #2 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 4 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Child  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15, 1933  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
4 0 0  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At home  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Charleston Mo.  
 13. NAME Robt. Hollins  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Miss.  
 15. MAIDEN NAME Annie Miller  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La Home Miss.  
 17. INFORMANT (ADDRESS) Robt. Hollins R30 #2 Charleston Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE Nov 15 33  
 19. UNDERTAKER (ADDRESS) Ken Ind. Co. 501 W. Main  
 20. FILED Nov 15 1933 F. D. Johnson  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15 A. 1933  
 22. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1933, to Nov 14, 1933.  
 I last saw him alive on Nov 14, 1933. Death is said to have occurred on the date stated above, at 3:30 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) A. H. Marshall M. D.  
 (Address) Charleston 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 should be given.

STATE DEPARTMENT ON BEING IN THIS IS A PERMANENT RECORD

