

OCT 20 1934

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

Do not use this space.

1. PLACE OF DEATH

County Monroe
Township Woodlawn
City (No. _____) _____

Registration District No. 587
Primary Registration District No. 1588

File No. 33486
Registered No. 5
St. _____ Ward _____

2. FULL NAME

Fayal Marie Holder
(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 MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/11/1934

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

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) Monroe Co. Mo

13. NAME Fayal Marie Holder

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co. Mo

15. MAIDEN NAME Emma Craig

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co. Mo

17. INFORMANT Fayal Marie Holder
(ADDRESS) Madison Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Dele Groves DATE 9/13/34

19. UNDERTAKER W. A. Thompson
(ADDRESS) Madison Mo

20. FILED 8/13/34 J. McElroy
Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 12 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:30 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebrally Induced Death
No Physicians
Other contributory causes of importance:
could not identify
at home

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____

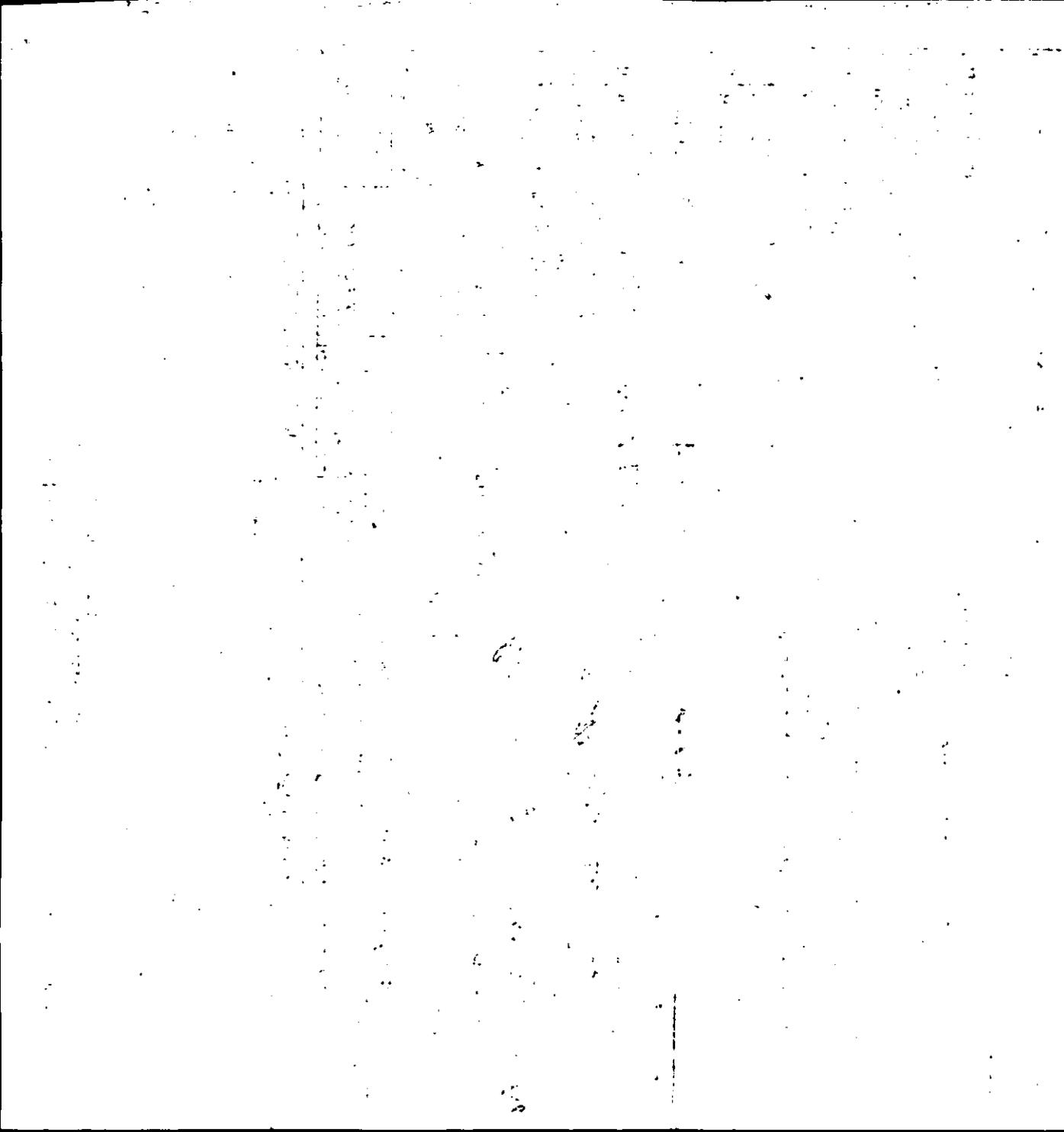
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) _____, M. D.
(Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death may be properly classified.



S-33486