

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

OCT 17 1935

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

Do not use this space.

28776

1. PLACE OF DEATH

County Buchanan
Township St. Joseph
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. 973
Registered No. 973
St. St. Joseph Hospital Ward

2. FULL NAME

(a) Residence, No. 6215 Washington St., Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 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) Feb. 5, 1924

7. AGE YEARS 11 MONTHS 7 DAYS 14 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. School
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Joseph, Missouri (STATE OR COUNTRY)

MOTHER FATHER 13. NAME William Hollaway

14. BIRTHPLACE (CITY OR TOWN) Kathena, Kansas (STATE OR COUNTRY)

15. MAIDEN NAME Oliver Grace

16. BIRTHPLACE (CITY OR TOWN) Halle, Missouri (STATE OR COUNTRY)

17. INFORMANT Mrs. William Hollaway (ADDRESS) 6215 Washington St. Joseph

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel Cem. DATE Sept. 23, 1935

19. UNDERTAKER Wm. D. Chalk (ADDRESS) St. Joseph, Mo.

20. FILED 9-22-35 John R. Sanders Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 19, 1935

22. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1935, to Sept. 19, 1935

I last saw him alive on Sept. 19, 1935 Death is said

to have occurred on the date stated above, at 11:15 A.M.

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

Acute osteomyelitis
in rt. scapula Date of onset 9/12/35

Other contributory causes of importance:

Acute tonsillitis 9/12/35

Name of operation Drainage of abscess scapula Date of 9/19/35

What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No

If so, specify

(Signed) C. S. Grant, M. D.

(Address) St. Joseph, Mo.



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

Do not use this space.

1. PLACE OF DEATH

County Buchanan

Registration District No. 83-

Township St Joseph

Primary Registration District No. 1001

City St Joseph (No.)

File No.

Registered No. 973

St. Ward

2. FULL NAME

Winston H Hollowell

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (write the word)

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.
11 7 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 11-7- 1935 John R. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19, 1935

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..... m.

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

Acute Osteomyelitis Date of onset

Not tuberculous origin

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) G. S. Grant, M. D.

(Address) St Joseph mo

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