DEC 18 1935

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

Do not use this space. Dr. J. H. Fulbright

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No. 35783
Township — Primary Registration District No. 12001 — Registered No. 607
City Springfield Mo. (No. 420 Holman St. Ward)

2. FULL NAME Rose E. Holman
(a) Residence, No. 420 Holman 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) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6-1861
7. AGE YEARS 74 MONTHS 4 DAYS 9 If LESS than 1 day, ...hrs. or ....min.

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

FATHER
13. NAME D. S. Holman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. C.

MOTHER
15. MAIDEN NAME Mary James
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Judge D. E. Holman Bro Springfield Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Hazelwood DATE Nov. 17 1935
19. UNDERTAKER (ADDRESS) Alma Lohmeyer Springfield Mo.
20. FILED 11 #17 1935 R W Langston Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 15, 1935
22. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1935, to Nov 15, 1935
I last saw her alive on 11/15 1935. Death is said to have occurred on the date stated above, at 1:30 P.M.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage — 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) J H Fulbright, M. D.
(Address) 225 1/2 South Ave

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 IS A PERMANENT RECORD