

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

Do not use this space.

39357

1. PLACE OF DEATH

County *Hamilton Hamilton*
Township *Hamilton*
City *Hamilton*

Registration District No. *337*
Primary Registration District No. *5473*

File No.
Registered No.
St. Ward)

2. FULL NAME

Francis Lidian Burr Holloway

(a) Residence No. *Hamilton Co. Mo.* St. *Mo.* Ward *...*

(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) *Married*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (or) WIFE OF *Geo. M. Holloway*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 4 1868*

7. AGE YEARS MONTHS DAYS *67 9 19* If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hamilton Twp., Hamilton Co., Mo.*

10. NAME OF FATHER *Wm. S. Bowen*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Wm. Virginia Maryland Co., Md.*

12. MAIDEN NAME OF MOTHER *Elizabeth Moore*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*

14. INFORMANT (Address) *Geo. M. Holloway, Hatfield, Mo. A.R.*

15. FILED *Dec 23 1935* *Louis Quinn* Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 23 1935*

17. I HEREBY CERTIFY, That I attended deceased from *1-15*, 1934, to *12-23*, 1935, that I last saw her alive on *12-18*, 1935, and that death occurred, on the date stated above, at *5:27 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lung Abscess
- Bronchiectasis -

(duration) *10* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic Myocarditis*

(duration) *5* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH *...*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF *...*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *none*

(Signed) *W. F. Proby*, M. D.

6-24, 1935 (Address) *Cogsville Mo*

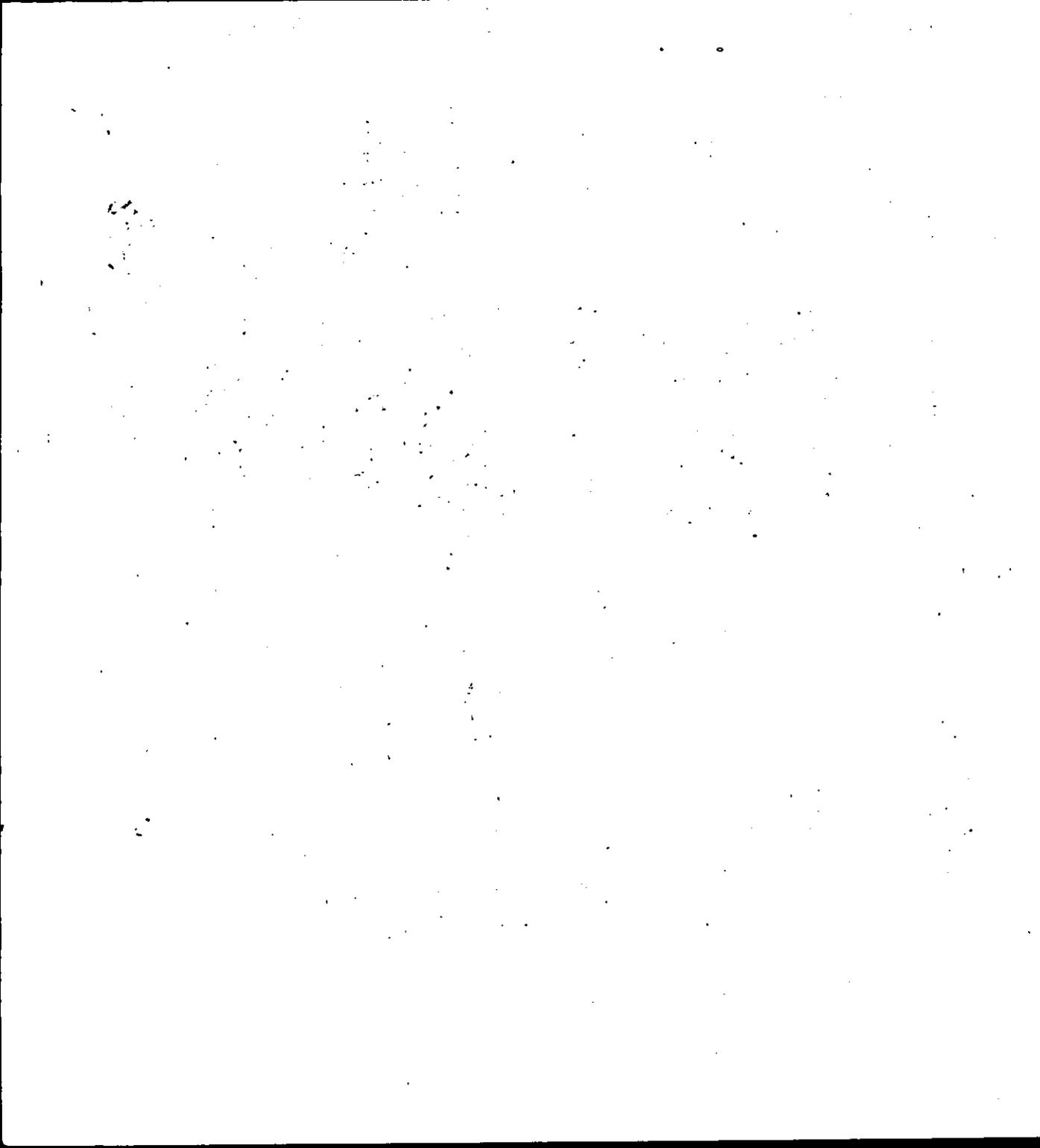
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Low Rock Cem., Hamilton Co., Missouri *12/24 1935*

20. UNDERTAKER ADDRESS *John S. White* *...*

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.



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1. PLACE OF DEATH

County Harrison Registration District No. 337 File No. _____
 Township Hamilton Primary Registration District No. 3473 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Francis Lidian B. Holloway

(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. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 23 1935

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

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.

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 19

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

Pneumonia
Bronchiectasis
Spontaneous test. wall
Consolidated pneumonia
for AB

Date of onset

Other contributory causes of importance:

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

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 Dec 25 1935

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) W. A. Broyles, M. D.

(Address) Flagville, Mo

Deputy Registrar

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.

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AMERICAN