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.

JAN 27 1937

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

Do not use this space.

1. PLACE OF DEATH

101 County Shannon — Registration District No. 823 — File No. 4588

Township Winona — Primary Registration District No. 6074 — Registered No.

City ..... (No. ....., 2 St. ..... Ward)

2. FULL NAME Nancy Jane Holloway Voyles

(a) Residence, No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

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 F — 4. COLOR OR RACE W — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 8, 1905

7. AGE — YEARS 31 — MONTHS 7 — DAYS 27 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ~~Laborer~~

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) Shannon Co Mo

FATHER

13. NAME John David Holloway

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

MOTHER

15. MAIDEN NAME Nellie Josephine Cowles

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

17. INFORMANT (ADDRESS) Robert Voyles Winona Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Cemetery Winona Mo DATE Jan 6, 1937

19. UNDERTAKER (ADDRESS) W. C. Cray Van Buren Mo

20. FILED 1-6, 1937 Mabel Rolling Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 5, 1937

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 8:00 A.m.

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

Date of onset

Respiratory Failure

Other contributory causes of importance:

Lobar Pneumonia

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) Frank Hyde, M. D.

(Address) Emmaus Mo

Co Health Physician