

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.

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

40609
Do not use this space.

1. PLACE OF DEATH

(a) County Washington 2 Registration District No. 886 ✓
(b) Township Belgrade 1 Primary Registration District No. 0183 Registered No. 9
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John William Hollingsworth

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 9, 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 10 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. retired farmer
10. Date deceased last worked at this occupation (month and year) 1930 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Shirley Mo. (STATE OR COUNTRY)

FATHER 13. NAME unknown

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

MOTHER 15. MAIDEN NAME Sarah Wilson

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

17. INFORMANT Fred Hollingsworth (ADDRESS) Belgrade Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Belgrade Mo. DATE Oct 23, 1938

19. FUNERAL DIRECTOR Norman White & Sons (ADDRESS) Ironton Mo.

20. FILED Nov 12, 1938 Ella White Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 21, 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1938, to Oct 20th, 1938
I last saw him alive on Oct 20th, 1938. Death is said to have occurred on the date stated above, at 7:00 A. m.
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia

Date of onset

10/10/38

Other contributory causes of importance:

Paralysis
Had been paralyzed for
some time

Name of operation None Date of
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?

If so, specify
(Signed) W. A. Houston, M. D.

(Address) Belgrade Mo

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

40609
Do not use this space.

1. PLACE OF DEATH
 (a) County Washington Registration District No. 885-
 (b) Township Belgrade Primary Registration District No. 6183 Registered No. 9
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John William Hollingworth
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
	<u>68</u>	<u>10</u>	<u>12</u>	

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

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

17. INFORMANT (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 21 1908

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:
Lobar Pneumonia Date of onset 10/5

Other contributor causes of importance:
Paralysis - Had been paralyzed for over 4 years
Agitated Paralysis (one word)

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 J. G. Houston M. D.
 (Signed) Belgrade Mo.
 (Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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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