

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

33781
Do not use this space.

1. PLACE OF DEATH
 (a) County Vernon 3 Registration District No. 875
 (b) Township Washington 1 Primary Registration District No. 6162 Registered No. 249
 (c) City Alexandria (d) Street No. State Hospital # 3 St.
 (e) Length of residence in city or town where death occurred 0 yrs. 0 mos. 17 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Holloway
 (a) Residence, No. _____ St. R#2, Brownington, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ?
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 24, 1877
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 | 6 | 30
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farming
 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) Johnston County, Mo
 FATHER 13. NAME William Holloway
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?
 MOTHER 15. MAIDEN NAME Matilda Cooper
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?
 17. INFORMANT (ADDRESS) Records, State Hosp # 3
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Clinton Mo DATE Sept 25, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred E. Wilkinson
 20. FILED Sept 23, 1939 Allen V. Hays
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 23, 1939
 22. I HEREBY CERTIFY That I attended deceased from Sept. 6, 1939 to Sept. 23, 1939
 I last saw him alive on Sept 23, 1939. Death is said to have occurred on the date stated above, at 10:15 a.m.
 The principal cause of death and related causes of importance were as follows:
Hyper-tension Heart Disease
4562
 Other contributory causes of importance:
Generalized Arterio Sclerosis
Rt. Sided Hemiplegia
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes
 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) Reese H. Potter, M. D.
 (Address) Alexandria, Mo.

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.

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1429

Date Filed 10-10-29

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.