DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34595

Registration District No. 791 Primary Registration District No. _____ Registrar's No. 9133

1. PLACE OF DEATH: 1003 NOV 13 1939

(a) County _____

(b) City or town St LOuis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3905 Russell Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3905 Russell Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William H Hollingsworth 4521

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anne 6 Hollingsworth

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct (Month) 8 (Day) 1867 (Year)

8. AGE: Years 72 Months 0 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Peoria (City, town, or county) Ill (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Retired

FATHER
12. Name J Littleton Hollingsworth
13. Birthplace unknown (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name Cecilia Brockett
15. Birthplace unknown (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Millrey Hollingsworth

(b) Address 3905 Russell

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct (Month) 26 (Day) 1939 (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director A Kron L & U Co

(b) Address 2707 N Grand Blvd

19. (a) OCT 25 1939 (Date received by registrar) (b) J F Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24 year 1939 hour 3 30 minute A M.

21. I hereby certify that I attended the deceased from Jan 1937 Oct 24, 1939, to _____, 19__; that I last saw him alive on Oct 23, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis & Hypertension

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature P B Cappel (M. D. or other)

Address 3239 Franklin ave Date signed 10-25-39

(Licensed Embalmer's Statement on Reverse Side)

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—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X19511

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 Paul F. Knollenberg

Licensed Embalmer No. 2631

P. O. Address 2707 N. Grand

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.