

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17520

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2047

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Days
(Specify whether
In this community 12 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 301 North Gladstone
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Mrs. Amanda E. Hollmann ⁴³³

8. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mr. John E. Hollmann 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 5 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 4 11 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name John D. Schlotelborg
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Dorothy Weidemann
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Louise D. Hollmann
(b) Address 301 N. Gladstone

17. (a) Removal (b) Date thereof May 17, 1940
(Burial, cremation, or removal) (City or town) (County) (State)
(c) Place: burial or cremation St. Peter's Cemetery
St. Louis, Missouri

18. (a) Signature of funeral director D. H. Newcomer, Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) May 17, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16th
year 1940 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from 5/5/40
19____, to 5/16/40, 19____;
that I last saw her alive on 5/16/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Lobar pneumonia
Due to 106

Other conditions mitral stenosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 D. H. Newcomer M. D. or other _____
Address 1103 Grand K. C. Ave signed 5/17/40

Duration
Physician
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1304 Professional Seal
12:30.5

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 C. Hervey Quisenberry
Licensed Embalmer No. 4070
P. O. Address K. C., Mo.

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.