

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 52

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(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 Missouri (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. 508 West Lincoln
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
year 1940 hour Two minute thirty P.M.
21. I hereby certify that I attended the deceased from 4-3-40
19____ to 4-5 19____
that I last saw him alive on 4-5 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Paraneuronal Nephritis

Due to _____
Due to _____
Other conditions _____
(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?
130
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W.G. Atwood (M. D. or other)
Address Carrollton Mo Date signed 5/6/40

8. (a) PRINT FULL NAME Lucy Jones Holloway
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, divorced, married

6. (b) Name of husband or wife Paul Holloway 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 11 22 1855
(Month) (Day) (Year)

8. AGE: Years 84 Months 5 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Andrew J. Jones
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Unknown
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant John C. Holloway
(b) Address Wakanda Mo

17. (a) Burial (b) Date thereof 5-7-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Adkins Cem

18. (a) Signature of funeral director Willis Marshall

(b) Address Carrollton Mo
19. (a) 5-6-40 (b) W.G. Atwood
(Date received local registrar) (Registrar's signature)

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

2
1 3-39
17-39
X21492

RECEIVED
District Health Officer No. 8,
District File Number PH-479
Date Filed _____

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 me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed H. B. Shillie
Licensed Embalmer No. 3861
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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18100

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 135

Primary Registration District No. 3010

Registrar's No.

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Lucy Jones Holloway

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Joe C. Holloway 6. (c) Age of husband, or wife, if alive about 85 years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 5 13 _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/6/60 (b) Ruth Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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?

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature W. B. Stwood (M. D. or other) _____

Address Carrollton Date signed _____

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

SUPPLEMENTAL

S-18100