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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22676

Registration District No. 757 FILED JUL 17 1940 Primary Registration District No. 3036 Registrar's No. 106

1. PLACE OF DEATH:

(a) County St Charles

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

(c) Name of hospital or institution: 116 N Tenth St
(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 St Charles

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

(d) Street No. 116 N. Tenth St
(If rural, give location)

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

3. (a) PRINT FULL NAME JOHN HERMAN HOLLRAH

3. (b) If veteran, name war .....

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Frederica Dickmann

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased November (Month) 3rd (Day) 1855 (Year)

8. AGE: Years 84 Months 7 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace St Charles County (City, town, or county) Mo (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name John D. Hollrah
13. Birthplace ~~Anna~~ (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Anna Bleekrede
15. Birthplace ..... (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Robert D Hollrah

(b) Address St. Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12th 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director Hackmann-Bone

(b) Address 326 N. 6th St. St Charles Mo

19. (a) 6/12/40 (Date received local registrar) (b) Clarence G. Wessler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10 year 1940 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 10th, 1940 to June 10, 1940 that I last saw him alive on June 10th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Strangulation	2.15 hr
Due to Angioneurotic Oedema of the glottis & Larynx	
Due to	
Other conditions Gen Arteriosclerosis (Include pregnancy within 3 months of death)	10 yrs

Major findings: Of operations None

Of autopsy None

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 A P Erich Schuh (M. D. or other)

Address St Charles Mo Date signed 6/12/40

(Licensed Embalmer's Statement on Reverse Side)

St Louis

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 Arthur C Bauer

Licensed Embalmer No. 3NV

P. O. Address St Charles Mo.

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

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