

JUL 22 1940

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

25987
Do not use this space.

1. PLACE OF DEATH
 (a) County Phelps Registration District No. 677
 (b) Township _____ Primary Registration District No. 4403 Registered No. 80
 (c) City Rolla, Missouri (d) Street No. McFarland Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 407 Ruby Holley
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 23, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
12 7 4

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. School girl
 9. Industry or business in which work was done, as saw mill, bank, etc. School girl
 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) Licking Mo

FATHER
 13. NAME O.D. Holley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Licking Mo

MOTHER
 15. MAIDEN NAME Dorrell Sears
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Licking Mo

17. INFORMANT (ADDRESS) R.F. Smith Licking Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Bronze Crest Bur DATE 6/28/40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith & Peterson Licking Mo

20. FILED June 28, 1940 Jos. F. Ayers Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 27, 1940

22. I HEREBY CERTIFY, That I attended deceased from June 20, 1940, to June 27, 1940.
 I last saw her alive on June 27, 1940. Death is said to have occurred on the date stated above, at 8:10 P.M.
 The principal cause of death and related causes of importance were as follows:
Sepsis following an eye infection!

Date of onset June 16, 1940

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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. Amey Ala Quake! M. D.
 (Signed) Amey Ala Quake!
 (Address) Rolla, Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD--

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

1 X1650

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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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 740 792

Licensed Embalmer No.....

Date Filed 7 22 80

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. **25987**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. **677**

Primary Registration District No. **4403**

Registrar's No. _____

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

R

1. PLACE OF DEATH:
 (a) County Shelby
 (b) City or town Ralla
(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 Ruby Holley
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widow, married, divorced 8

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

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

8. AGE: Years 12 Months 7 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) _____
(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 June day 27
 year 1970 hour _____ minute _____ M.

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

Immediate cause of death: Septicemia following eye infection
 Due to: primary infection of eye (probably pyoderma)

Other conditions: _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: 36
 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? _____

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

23. Signature H. A. Drake (M. D. or other) _____
 Address Ralla Mo Date signed _____

SUPPLEMENTARY

