

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1874

1. PLACE OF DEATH:  
(a) County Saint Louis  
(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Veterans Administration Facility  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Adm: 7-27-35  
(Specify whether  
In this community, ---  
years, months or days)

8. (a) PRINT FULL NAME AMES HOLLINGSHEAD

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Div.

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

7. Birth date of deceased May 20, 1896  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>44</u>	<u>4</u>	<u>13</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business ---

12. Name Sarah Cassidy

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

14. Maiden name Jap Hollingshead

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

16. (a) Informant's own signature C. W. Hughes

(b) Address VAF., Jefferson Barracks, Mo.

17. (a) DURIAL (b) Date thereof OCT 7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEM

18. (a) Signature of funeral director C. W. Hughes

(b) Address 244 1940

19. (a) OCT 24 1940 (b) C. W. Hughes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County ---  
(c) City or town Iron Mountain  
(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 October day 3  
year 1940 hour 4 minute :00 P. M.

21. I hereby certify that I attended the deceased from July 27  
1935, 19\_\_\_\_, to October 3, 19 40

that I last saw him alive on October 3, 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary chronic,  
active, far-advanced. Duration unkn.

Due to ---

Due to ---

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations No operations

Of autopsy No 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) Manner of injury ---

23. Signature C. W. HUGHES, M.D. Chief (M. D. or other) Officer

Address VAF Jefferson Bks., Mo. Date signed 10-4-40

WHILE FAMILIAR TO USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

NOV 25 1940

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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.

Signed *L. C. Hoffmeister*

Licensed Embalmer No: *3871*

P. O. Address *7814 S. Broadway*

**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.**