No. 2
4-13-40
5-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 40558

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 10329

**1. PLACE OF DEATH:**

(a) County: 1

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

(c) Name of hospital or institution: Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo. (b) County: ____

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 5734 Vernon Ave. 5
(If rural, give location)

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

3. (a) PRINT FULL NAME: William M. Holman

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: Adelane Holman

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

7. Birth date of deceased: Sept. (Month) 14 (Day) 1866 (Year)

8. AGE: Years 74 | Months 3 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace: Telegrapher (City, town, or county) La. (State or foreign country) 1

10. Usual occupation: Telegrapher 9

11. Industry or business: Retired

MOTHER FATHER

12. Name: Unknown 9

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

14. Maiden name: Unknown

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

16. (a) Informant: Adelane Holman

(b) Address: 5734 Vernon Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation: New St Marcus Cem.

18. (a) Signature of funeral director: Drehmann-Harral

(b) Address: 1905 Union Blvd.

19. (a) DEC 17 1940 (Date received local registrar) (b) J. F. Breder (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 16 year 40 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 23, 1940, to Dec. 16, 1940, that I last saw him alive on Dec. 16, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Major findings: ____
Of operations: ____

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: Robert N. Tindall (M. D. or other)

Address: Mo. Pacific Hospital Date signed 12/16/40

(Licensed Embalmer's Statement on Reverse Side)

## 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 Warren A. Carve

Licensed Embalmer No. 3534

P. O. Address.....

**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, fact should be so stated above.**