S. No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB MAR 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6484

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 45

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

14 / 2

1. PLACE OF DEATH:
(a) County Calloway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)
In this community 29 yrs. 0 - 3 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Calloway 14
(c) City or town Fulton / 2
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Agatha Holcroft
3. (b) If veteran, name war ____
3. (c) Social Security No. None.
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased April (Month) 5 (Day) 1852 (Year)
8. AGE: Years 89 Months 10 Days 8 If less than one day ____ hr. ____ min.
9. Birthplace Georgetown (City, town, or county) / Kentucky (State or foreign country)
10. Usual occupation Invalid
11. Industry or business ____
FATHER 12. Name W. S. Hollcroft
13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Rebecca Cartwright
15. Birthplace ____ / Kentucky (City, town, or county) (State or foreign country)
16. (a) Informant Chas L Lazing
(b) Address Columbia, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 13, 1941. (Month) (Day) (Year)
(c) Place: burial or cremation Columbia Cem.
18. (a) Signature of funeral director Clarkson
(b) Address Columbia, Mo
19. (a) Feb 13/41 (Date received by registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13th year 1941 hour 4 minute 15 P. M.
21. I hereby certify that I attended the deceased from February 2, 1941, to Feb 13, 1941; that I last saw her alive on Feb 13, 1941; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Chronic Myocarditis
Due to Arterio sclerosis
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature Forest Thomas (M. D. or other) D
Address State Hospital No 1 Fulton Mo Date signed ____

(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.....

Licensed Embalmer No. 4732

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, fact should be so stated above.