

No. 2
1-4-41
5-17-39
X26390

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2621 CAROLINE ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
City Hospital (Specify whether
in this community _____
years, months or days)

3. (a) PRINT FULL NAME ROBERT F. HOLWAY
3. (b) If veteran, name war NO
3. (c) Social Security No. 499-03-5297

4. Sex MALE 5. Color or race WHITE
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 MARCH 11 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 3 6 hr. min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation MAINTANES MAN
11. Industry or business KECH HOSPITAL
12. Name JAMES HOLWAY
13. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)
14. Maiden name ANNA FARRELL
15. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

16. (a) Informant Eva Holway
(b) Address 1818 S. 12th ST

17. (a) BURIAL (b) Date thereof JUNE 21-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation VALHALLA CEM.

18. (a) Signature of funeral director E. J. Schurer
(b) Address 3125 Lafayette av.

19. (a) JUN 21 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 100
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 2217
(d) Street No. 2621 CAROLINE (If street give location) 9
(e) Citizen or foreign country Attending Physician (Specify or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 20
year 1941 hour 11 minute 55 P.M.

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

Immediate cause of death: Chronic Myocarditis
Chronic Interstitial Nephritis
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 131A
Of operations _____
Of autopsy _____

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) (c) Means of injury 5
23. Signature Thomas H. Callanan (M. D. or other)
Address Deputy Coroner Date signed 9/21/41

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:.....

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.