No. 2
-11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34818

Registration District No. 287 Primary Registration District No. 5405 Registrar's No.

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

500

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Rural - Clay Tp.
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: 35
(a) State Mo. (b) County Franklin
(c) City or town Hamersville Rural
(If outside city or town limits write "RURAL")
(d) Street No. 4 miles N. 2 miles East
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Adey S. Hollingsworth
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W.
6. (a) Single, widowed, married, divorced D
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 21 (Day) 1941 (Year)

8. AGE: Years	Months	Days	If less than one day
	1	10	hr. min.

9. Birthplace Hamersville (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Infant
11. Industry or business
FATHER 12. Name James Hollingsworth
13. Birthplace Waters (City, town, or county) Ark. (State or foreign country)
MOTHER 14. Maiden name Beebe Kearns
15. Birthplace Shirley (City, town, or county) Ark. (State or foreign country)
16. (a) Informant
(b) Address
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-41 (Month) (Day) (Year)
(c) Place: burial or cremation Hamer
18. (a) Signature of funeral director Emerson-Burns
(b) Address Hamersville, Mo.
19. (a) 10-6-41 (Date received by local registrar) (b) E. G. Cope (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5 year 1941 hour 9 minute a.m.
21. I hereby certify that I attended the deceased from Oct. 2, 1941, to Oct. 5, 1941, that I last saw h alive on Oct. 4, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gastro-Enteritis	7 hrs
Due to Non assimilation of food	1 mo
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 E. G. Cope (M. D. or other) M.D.
Address Hamersville Mo. Date signed 10/6/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1141-1536
Date Filed 11/12/41

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, above space should be left blank.

. S. No. 2B
DM—8-21-41
I X29268

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

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34818

Registration District No. 287 Primary Registration District No. 5405 Registrar's No.

1. PLACE OF DEATH:
(a) County: Franklin
(b) City or town: Rural
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Odey S. Hollingsworth
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Aug (Month) 21 (Day) 1941 (Year)

8. AGE: Years | Months: 1 | Days: 10 | If less than one day hr. min.

9. Birthplace: Mo. (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: James Hollingsworth
(b) Address: Dinersville Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

diw