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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 10 1942

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

State File No. 116263

Registrar's No. 4724

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days. (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin

(c) City or town West Frankfort (If outside city or town limits, write "RURAL")

(d) Street No. 1303 E. Poplar Street., (If rural, give location)

(e) Citizen of foreign country? N.R. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edna Ruth Holland

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Earl Holland

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased February 16, 1896 (Month) (Day) (Year)

8. AGE: Years 46 Months 3 Days 12 If less than one day hr. min.

9. Birthplace Effingham (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jerome Gloyd
13. Birthplace Unknown (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Mary V. Bradley
15. Birthplace Effingham (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Earl Brice Holland

(b) Address 1303 E. Poplar, W. Frankfort

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/29/42 (Month) (Day) (Year)

(c) Place: burial or cremation Marion, Illinois

18. (a) Signature of funeral director Albert H. Hoppe Inc

(b) Address 4700 Washington Blvd.,

19. (a) MAY 29 1942 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28 year 1942 hour 6:30 minute P M.

21. I hereby certify that I attended the deceased from May 26, 1942, to May 28, 1942 that I last saw her alive on May 28, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Brain Tumor

Non-malignant

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Brain Tumor, 25 Frontal

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Charles Elbert (M. D. or other) M.D.

Address BARNES HOSPITAL Date signed 5/28/42

844 (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 J. S. Sullivan

Licensed Embalmer No. 1122

P. O. Address City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
8-21-41
I X29288

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16263

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 4724

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: Barnes Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County Franklin
(c) City or town West Frankfort
(If outside city or town limits, write "RURAL")
(d) Street No. 1303 E. Poplar St
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Edna Ruth Holland

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Feb 16 (Month) 1896 (Day) (Year)

8. AGE: Years 46 Months 2 Days ..... If less than one day ..... hr. ..... min.

9. Birthplace ..... (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 .....
(b) Address .....

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) JUL 17 1942 (Date received local registrar) (b) J. F. Bredesen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28 year 1942 hour 3 minute 30 P.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.

Immediate cause of death ..... Duration

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? .....
While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

1942
S-16263