

V. S. No. 2
FORM-2-43
Rev. 5-17-39
I. 1-1-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23093**
Registrar's No. **6980**

AUG 12 1943
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis, mo
(b) City or town St. Louis, mo
(c) Name of hospital or institution: PARK LANE HOSPITAL
(d) Length of stay: In hospital or institution 6 Days
In this community 6 Days
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
(c) City or town ST LOUIS 17
(d) Street No. 728 BAYARD 71
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Hollis, Mrs. Florence
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife CHESTER HOLLIS 6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased MAY 19 1903
(Month) (Day) (Year)

8. AGE: Years 40 Months 2 Days 12 If less than one day hr. min.

9. Birthplace SWIFTON ARK.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Bill Sockett

MOTHER FATHER

12. Name BILL SOCKETT

13. Birthplace INDIANAL
(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 Mrs. Hollis

(b) Address Conroy, Arkansas

17. (a) REMOVAL (b) Date thereof AUG 2 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SWIFTON, ARK

18. (a) Signature of funeral director ORBY FUNERAL HOME

(b) Address CORNING, ARK

19. (a) AUG 2 1943 (b) J. F. Bredeek
(Date received locally) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 1
year 1943 hour 9:35 minute P. M.

21. I hereby certify that I attended the deceased from 5-28-43, 19, to 8-1-43, 19,
that I last saw her alive on 8-1-43, 19,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Chronic interstitial nephritis

Due to Chronic interstitial nephritis
Due to Myocarditis
Other conditions (Include pregnancy within 3 months of death) 1/2/1

Major findings: Of operations 1/2/1
Of autopsy 1/2/1

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? _____
(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 _____

3. Signature J. F. Bredeek (M. D. or other) MD
Address _____ Designated 8-2-43

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.

e

Signed.....

John Ketter
Licensed Embalmer No. 3880

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.