

AUG 5 1948
Registration District No. 42

Primary Registration District No. 1000

20 Registrar's No. 746

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph.
(c) Name of hospital or institution: 315 Virginia
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 515 Virginia St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME William Harrison Hollowell.
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower.
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Dec. 27, 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 5 2 hr. min.

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

10. Usual occupation Laborer, retired 20 years.

11. Industry or business.....

MOTHER FATHER
12. Name Charles Hollowell
13. Birthplace Penn.
(City, town, or county) (State or foreign country)
14. Maiden name Ella Gaylor
15. Birthplace Unknown.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J.E. Stanturf,
(b) Address 515 Virginia St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 8-1-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Register Cemetery, St. Joseph,

18. (a) Signature of funeral director L. D. Clark
(b) Address 5025 King Hill Ave. St. Joseph, Mo.

19. (a) 6-1-43 (b) Rose Perry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 29, 1948.
year hour minute P. M.
21. I hereby certify that I attended the deceased from May 17
1948, to May 27, 1948
that I last saw him alive on May 27, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute
dehidration & Head.
Due to Acute testicular
Sanctity. testicular
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 95ct
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) (e) Means of injury 2
23. Signature W. H. T. Tupper (M. D. or other) 100.
Address 411 West 11th St. St. Joseph, Mo. Date signed 8-1-48

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Fred W. Clark

Licensed Embalmer No. 1859. 4239

P. O. Address St. Joseph, Mo.

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.