

FILED SEP 9 1943 4

Registration District No. 254

Primary Registration District No. 438-6-5811

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Thayer (Rural) Thayer, Ore
(c) Name of hospital or institution: 1
(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 Oregon
(c) City or town Thayer (Rural)
(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 Thomas Leon Holloway

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, Single

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

7. Birth date of deceased August 1 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 hr. 45 min.

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

10. Usual occupation Infant

MOTHER FATHER { 11. Industry or business

12. Name Thomas Holloway
13. Birthplace Moko Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Nora Erey
15. Birthplace Thayer Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Holloway

(b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 8/2/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Two Mile Cem.

18. (a) Signature of funeral director None

(b) Address

19. (a) 8-10-43 (b) Jae D. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1
year 1943 hour 5 minute 00 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 Premature birth Duration

Due to Fall of mother
Due to.....

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

Major findings:
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)
(e) Means of injury.....

23. Signature Metcheu Blaine (M. D. or other)
Address Man. Sp. g. Act Date signed 8-2-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

75
00

75
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1112

RECEIVED

District Health

Officer No. 5,

District File Number

943334

Date Filed

9-7-43

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.

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.