

S. No. 2  
4-9-4-41  
5-5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35453

State File No.

FILED NOV 9 1943  
Registration District No. 1243

Primary Registration District No. 5909

Registrar's No. 71

1. PLACE OF DEATH: *Geniescot*  
 (a) County. *Geniescot*  
 (b) City or town. *Carruthersville Rural*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: *Little Prairie*  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution *None* (Specify whether  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State. *MO* (b) County. *Geniescot*  
 (c) City or town. *Carruthersville Rural*  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) *07800*  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *Gideon Holloway*  
 3. (c) Social Security No. \_\_\_\_\_  
 (b) If veteran, name war \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month *11-2* / *1943*  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex *M*  
 5. Color or race *B*  
 6. (a) Single, widowed, married  
 divorced \_\_\_\_\_  
 (b) Name of husband or wife *Mrs Gideon Holloway* (c) Age of husband or wife if  
 alive \_\_\_\_\_ years  
 7. Birth date of deceased (Month) (Day) (Year)

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.

8. AGE: Years Months Days If less than one day  
*About 42* \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death *acute alcoholism*  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 10. Usual occupation *Farm Labor*

Other conditions (Include pregnancy within 5 months of death) *17C*  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name *not known*  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name *not known*  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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)

16. (a) Informant *Yoush Tistadt*  
 (b) Address *Carruthersville MO*  
 17. (a) *Burial* (b) Date thereof *11-2-43*  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation *L. Prairie Twpshp*  
 18. (a) Signature of funeral director *Friends*  
 (b) Address \_\_\_\_\_  
 19. (a) *11-2-1943* (b) *Jessie N. Marney*  
 (Date received local registrar) (Registrar's signature)

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

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury *Heel of foot*  
 23. Signature *Fred Ogitvie* (M. D. or \_\_\_\_\_)  
 Address *Carruthersville MO* Date signed *11/2/43*

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

78000

10-43-289

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**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.**