

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 10 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 331

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Richardsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 - Day
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Mary Belle Holohan

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 2

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

7. Birth date of deceased 9 27 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 3 27 hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER { 12. Name West
13. Birthplace don't know (City, town, or county) (State or foreign country)
14. Maiden name Moretha Williams
15. Birthplace don't know (City, town, or county) (State or foreign country)

16. (a) Informant Chas. G. Holohan

(b) Address Madison Mo.

17. (a) Burial (b) Date thereof 12-26-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director Fred Thayer

(b) Address Madison Mo.

19. (a) 12/27/43 (b) Mrs. J. L. Wayne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe
(c) City or town Madison
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day Twenty Year 1943 hour Five minute 25 P.M.

21. I hereby certify that I attended the deceased from December Seventeenth, 1943, to December 24, 1943, that I last saw her alive on December 24, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to hypertension

Due to arteriosclerosis

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations No operations

Of autopsy No 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 A. R. Scholtz Date signed 12/27/43
Address Community Nursing Home

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

1044

(Licensed Embalmer's Statement on Reverse Side)

41403

RECEIVED

District Health Officer No. 10

District File Number 1-44-24

Date Filed JAN 7 1944

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 3907

....., Registered Apprentice No.
working under my personal supervision.

Signed Lauria Riley

Licensed Embalmer No. 3907

P. O. Address Kirksville 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.