

FILED JAN 11 1944  
Registration District No. **294**

Primary Registration District No. **3056**

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

1. PLACE OF DEATH:

(a) County **Randolph**  
(b) City or town **Moberly**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**McCormick Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 days**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Randolph**  
(c) City or town **Moberly**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **600 Farrar**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME **Catherine T. Holohan**

3. (b) If veteran, name war  (c) Social Security No.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Temple Holohan** 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased **Apr 14<sup>th</sup> 1912**  
(Month) (Day) (Year)

8. AGE: Years **31** Months **8** Days **11** If less than one day hr. min.

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

10. Usual occupation **At home**

11. Industry or business

12. Name **James Brennan**

13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bridget Dooey**

15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Temple Holohan**

(b) Address **Moberly, Mo.**

17. (a) **Burial** (b) Date thereof **Dec 27<sup>th</sup> 43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Moberly Mo**

18. (a) Signature of funeral director **Mahar and Son**

(b) Address **Moberly Mo**

19. (a) **12-26-43** (b) **Irma Kaul**  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec**, day **25<sup>th</sup>**, year **1943** hour **6:15** minute **a.m.**

21. I hereby certify that I attended the deceased from **December 21**, 1943, to **Dec 25**, 1943; that I last saw her alive on **Dec 25**, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death **following gall bladder removal**

Due to **cholelithiasis & cholecystitis**

Due to **126**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **stones in gall bladder**

Of autopsy

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

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. L. McCormick** (M. D. or other) **MD**  
Address **Moberly Mo** Date signed **12-28-43**

1056

**RECEIVED**

**District Health Officer No. 10**

District File Number 1-44-60

Date Filed JAN 10 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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Frank D. Hill  
Licensed Embalmer No. 2021  
P. O. Address Mokey, 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.**