

FILED FEB 11 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1039

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4040 Olive St. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4040 Olive St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Holloman

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

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
About 1891  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 52 hr. min.

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

10. Usual occupation Filing Clerk

11. Industry or business

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

16. (a) Informant Mable Thorp  
(b) Address 4040 Olive St.

17. (a) Burial (b) Date thereof 2-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe, Inc.  
(b) Address 4700 Washington Blvd.

19. (a) FEB 1 1944 (Date received local registrar)  
J. F. Briden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31  
year 1944 hour 2 minute 50 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  
Coronary Occlusion  
Coronary Sclerosis

Due to \_\_\_\_\_  
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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed 2/1/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

*W. Wilkinson*

Licensed Embalmer No..... *3575*

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.**