

No. 2
-5-43
-17-39
X.3.1771

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3608

State File No. _____

FILED JAN 29 1944

Registration District No. _____

Primary Registration District No. 5787

Registrar's No. 75

1. PLACE OF DEATH:

(a) County MISSISSIPPE
(b) City or town RURAL ST James Twp
(c) Name of hospital or institution: Yes, 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 9 mo, 7 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miss 67
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No 7 miles South of E. Prairie, Mo (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME THOMAS JAMES HOLMAN

3. (b) If veteran, name war ✓ 3. (c) Social Security No. None

4. Sex MALE 5. Color or race NEGRO 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 FEB 22 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 7 hr. min.

9. Birthplace MISSISSIPPE CO. MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER

12. Name ABRAHAM HOLMAN

13. Birthplace WINSTON CO. MISS 1
(City, town, or county) (State or foreign country)

14. Maiden name ROSA SPARKS

15. Birthplace PHILLIPS CO ARK 1
(City, town, or county) (State or foreign country)

16. (a) Informant Abraham Holman

(b) Address East Prairie, Mo Rt 2

17. (a) Burial (b) Date thereof Dec 1 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE

18. (a) Signature of funeral director Charles Shelby

(b) Address East Prairie Mo

19. (a) 1-10-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 30 year 1942 hour 80 minute 24 A.M.

21. I hereby certify that I attended the deceased from Nov 29, 1942 to Nov 28, 1943; that I last saw him alive on Nov 28, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration D.K.

Due to _____

Due to _____

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

Major findings: Of operations _____ Of autopsy 107

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) (c) Means of injury _____

23. Signature [Signature] (M. D. or other) 0
Address Charleston Mo Date signed 12/1/43

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

1271

RECEIVED

District Health Office, No. 2,

District File Number 144-155

Date Filed 1-18-44

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.

Not embalmed

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.