

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7179

State File No. _____
Registrar's No. 2208

FILED MAR 8 1944
Registration District No. 120

Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1702 W. THOMAN
(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)

3. (a) PRINT FULL NAME THOMAS D. HOLCOMB.
3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MARCELLA V. HOLCOMB 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased JUNE 12, 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Urb. TENN. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Laborer

MOTHER FATHER { 12. Name Jim Holcomb
13. Birthplace Urb. Tenn. 1
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Urb. Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Marcella V. Holcomb

(b) Address SPRINGFIELD MO.
17. (a) Burial (b) Date thereof March 2 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director J. W. Thompson & Co.
(b) Address SPRINGFIELD MO.

19. (a) 2-2-44 (b) W. H. Hurd
(Date received local registrar) (Registrar's signature)

984 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County GREENE 39
(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 1702 W. Thoman
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 29th
year 1944 hour 6 minute 30 P. M.
21. I hereby certify that I attended the deceased from 2/23 1944 to Feb 29 1944
that I last saw him live on give on Feb 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none Of autopsy no
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 J. F. Freeman (M. D. or other) _____
Address Springfield Mo Date signed 3/1/44

APR 3 1963

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 Roy A. Cowin
Licensed Embalmer No. 1763
P. O. Address Shirlington

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.

[Handwritten mark]