

No. 2  
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17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 10 1944**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

7700

State File No. ....

Registration District No. 199

Primary Registration District No. 4811

Registrar's No. 4

**1. PLACE OF DEATH:**

(a) County Macon

(b) City or town Callas  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -  
(Specify whether years, months or days)

In this community -  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Macon

(c) City or town Callas  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** John T. Holman

3. (b) If veteran, name war -

3. (c) Social Security No. -

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Feb day 9  
year 1944 hour 9 minute 30 A M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maudie Holman

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased: (Month) 8 (Day) 1 (Year) 1885

21. I hereby certify that I attended the deceased from 12-31, 1943, to 2-9, 1944; that I last saw him alive on 2-9, 1944; and that death occurred on the date and hour stated above.

8. **AGE:**

Years	Months	Days	If less than one day
<u>64</u>	<u>6</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Cerebral Apoplexy Duration 16 hrs.

Due to Cardio-vascular - renal disease several years

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

9. Birthplace Callas Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

Other conditions 13/a  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

12. Name John Holman

13. Birthplace Randolph Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Matilda Willson

15. Birthplace Macon Mo  
(City, town, or county) (State or foreign country)

Major findings: 13/a

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Maudie Holman

(b) Address Callas Mo

17. (a) Burial (b) Date thereof 2-13-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Callas

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? \_\_\_\_\_

18. (a) Signature of funeral director H. S. Edwards

(b) Address 13 W. 13th

19. (a) Feb 13, 1944 (b) H. J. Allen  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury

23. Signature H. J. Allen Date signed 2/10/44

Address Callas Mo

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

MOTHER FATHER

1043

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 3-44-450

Date Filed MAR 4 1911

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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 A. G. Edwards

Licensed Embalmer No. 1961

P. O. Address Beverly, 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.