

FILED APR 16 1944  
Registration District No. 169944

Primary Registration District No. 5273

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Christian  
(b) City or town rural - Porter  
(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 \_\_\_\_\_)  
In this community 46yrs  
years, months or days

3. (a) PRINT FULL NAME Catharine Hollingshead

3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April, 23, 1856  
(Month) (Day) (Year)

8. AGE: Years 87 Months 10 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

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

MOTHER FATHER { 12. Name Wolf Kuntsman

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

14. Maiden name Sophia Schaffer

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

16. (a) Informant's own signature Mrs. Grace Keltner

(b) Address Nixa, Mo.

17. (a) burial (b) Date thereof 3-16, 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mishawaka, Ind.

18. (a) Signature of funeral director T.W. Maples

(b) Address Clever, Mo.

19. (a) Mar. 14, 1944 (b) Edna B. Wood  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian  
(c) City or town rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Nixa, Route #1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12  
year 1944 hour 1 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Dec 31, 1943, to March 11, 1944

that I last saw h.w. alive on March 9, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death acute, reflex Duration 2 da

Drop Organic disease of heart and arteriosclerosis 2 yrs

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

Other conditions fluently  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy None

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) X

(b) Date of occurrence X

(c) Where did injury occur? X (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 \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature T.B. Hanson (M. D. or other)

Address Nixa, Mo. Date signed 3/17/44

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1248

RECEIVED

District Health Officer No. 61

District File Number 444-465

Date Filed APR 12 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 \_\_\_\_\_

*J.W. Maples*

Licensed Embalmer No. *2985*

P. O. Address *Cleveland, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

*April*  
*6*

Registration District No. *69*

Primary Registration District No. *5273*

Registrar's No. *6*

1. PLACE OF DEATH:

(a) County *Christian*  
(b) City or town *Rural Parker Twp*  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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

*Catherine Hollingshead*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased *April 22 1906*  
(Month) (Day) (Year)

8. AGE: Years *87* Months *10* Days \_\_\_\_\_ If less than one day, \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* Day *12* Year *1948* Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

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 *H. B. Hanson* (M. D. or other) \_\_\_\_\_

Address *Hija, Mo.* Date signed *4/16/48*

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

**SUPPLEMENTARY**  
*Had an attack of acute nephritis 18 months ago, now fully recovered*

10679