

FILED MAY 17 1944

Registration District No. 381 Primary Registration District No. 6179 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Sullivan

(b) City or town Jackson Twp. Pollock, Mo.  
(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 50 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town Pollock, Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Jackson Twp.  
(If rural, give location)

(e) Citizen of foreign country? Mo. (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Cynthia Ann Holliday

3. (b) If veteran, name war Mo.

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4, year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife Thomas Holliday

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March 4, 1883  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1, 1943 to April 4, 1944 that I last saw her alive on April 4, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes, Coma Duration 3 days

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>1</u>	<u>0</u>	hr. _____ min. _____

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

10. Usual occupation at home

Due to Diabetes Mellitus 10 years

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

Other conditions Respiratory  
(Include pregnancy within 2 months of death)

Major findings: of right foot

MOTHER FATHER

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

12. Name Elija Burkhart

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

14. Maiden name Anna M. Data

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

Of autopsy 61

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Edgen Holliday

(b) Address Milan, Mo.

17. (a) burial (b) Date thereof Apr. 6, 1944  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Scopes Cem. April, 1944

18. (a) Signature of funeral director Schoene's Funeral Service

(b) Address Milan, Mo. F.D. Schoene

19. (a) May 10, 1944 Mrs. L. D. Green  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

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)

Means of injury \_\_\_\_\_

23. Signature LeRoy F. Judd (M. D. or other) \_\_\_\_\_

Address Pollock, Mo. Date signed 4/16/44

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

RECEIVED

District Health Officer No. 10

District File Number 5-44-1018

Date Filed MAY 15 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 Frank D. Schoene

Licensed Embalmer No. 2016

P. O. Address Milan

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.