

FILED JAN 17 1945  
Registration District No. 1799

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
3024 Bellaire Ave  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community 43 Years / \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Melissa Jane Holloway

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe.

5. Color or race White

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

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

6. (c) Age of husband or wife if deceased Deceased years

7. Birth date of deceased Feb. 16th, 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days 76 10 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Clara Scott

(b) Address 3024 Bellaire Ave

17. (a) Removal (b) Date thereof 1/3/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains Mo.

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St.

19. (a) 1-3-45 (b) D. E. Brown  
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3024 Bellaire  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 2  
year 1945 hour 11:00 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb. 20 1944 to Jan 2 1945  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Chronic Hypertension

Due to Gen Senility with  
Arterio-sclerosis

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

Other conditions Chronic Interstitial Nephritis  
(Include pregnancy within 3 months of death)

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

Of autopsy 13!

10 days  
10 yrs.  
10 yrs.

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? \_\_\_\_\_

23. Signature Joseph A. Logan  
Address 402 Northman Dr Date signed 1/2/45  
(Specify type of place) (Means of injury)

R.C.S.M.

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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

*John B. Camp*  
.....  
Licensed Embalmer No. *2955*  
.....  
P. O. Address *K.C. 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.**