

FILED FEB 19 1945

Registration District No. _____

Primary Registration District No. 4125

State File No. _____

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Revere
(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 _____
In this community Intire life / (Specify whether years, months or days)

3. (a) PRINT FULL NAME DANIEL GALLAND

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

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

6. (b) Name of husband or wife Louisa Miller Holland 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Sept. 7 1857
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 14 If less than one day hr. _____ min. _____

9. Birthplace Revere Clark Co. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired farmer

12. Name Isaac Holland
13. Birthplace Union Co. Ohio (City, town, or county) (State or foreign country)
14. Maiden name Margaret Parsons
15. Birthplace Union Co. Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mary M. Johnson
(b) Address Revere Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Holland Cemetery, Revere

18. (a) Signature of funeral director Mr. H. W. E. Spierhart
(b) Address Revere, Mo.

19. (a) 1-25-45 (b) Phyllis Boston (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark
(c) City or town Revere (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21
year 1945 hour 7:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from Nov 10 1944 to Jan 21 1945
that I last saw him alive on Jan 21 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Aortic Insufficiency
Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92a
Of autopsy _____

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 J. L. McConnell (M. D. or other) _____
Address Revere Date signed 1-23-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3000

RECEIVED

District Health Officer No. 10

District File Number 2-45-328

Date Filed FEB 11 1945

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..... H. F. Kincher.....

Licensed Embalmer No. 2611

P. O. Address Wayland

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.