S. No. 2
DM—2-43
v. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15903

Registration District No. 149 | Primary Registration District No. 1002 | Registrar's No. 2132

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.T.B. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 Days. (Specify whether
In this community 12 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City, Mo. 48
(If outside city or town limits, write "RURAL")
(d) Street No.: 1105 East 10th 3
(If rural, give location) 8
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Delmar A. Holloway
3. (b) If veteran, name war: no
3. (c) Social Security No. 487-09-3439
4. Sex: M. 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Divorced 3
6. (b) Name of husband or wife: Ella May
6. (c) Age of husband or wife if alive: 20 years
7. Birth date of deceased: Nov. (Month) 20 (Day) 1899 (Year)

8. AGE: Years 45 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace: Quincy (City, town, or county) Ill. (State or foreign country) 1
10. Usual occupation: Laborer.
11. Industry or business
FATHER
12. Name: W. H. Holloway 1
13. Birthplace: Quincy (City, town, or county) Ill (State or foreign country) 1
MOTHER
14. Maiden name: Emma Addison
15. Birthplace: Excelsior Springs, (City, town, or county) Mo. (State or foreign country) 0
16. (a) Informant: E. T. Holloway
(b) Address: 3915 Windsor Kc Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Honey Creek Cemetery Mo.
18. (a) Signature of funeral director: Geo H. Long
(b) Address: 703 N. 10 St. K.C. Mo.
19. (a) 5-17-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-15 day year 1945 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from 4-24 1945 to 5-15 1945; that I last saw him alive on 5-15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis — Duration 1 yr. approx.
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death): 13 B
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. L. Coffman (M. D. or other) 40
Address: Kansas City Date signed 5-15-45

(Licensed Embalmer's Statement on Reverse Side)

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. Louis A. Long

Licensed Embalmer No. J 3417

P. O. Address .....

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.