

No. 2  
1-5-43  
5-17-39  
I X36871

FILED JUN 13 1945  
Registration District No. 5753

Primary Registration District No. 5753

Registrar's No. 69

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution; write street number or location)

(d) Length of stay: In hospital or institution 48 days  
(Specify whether In this community 48 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin

(c) City or town Circleville  
(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 John Henry Hollis

3. (b) If veteran, name war no

3. (c) Social Security No. unknown

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased December 22 1913  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27  
year 1945 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from April 10 1945 to May 27 1945  
that I last saw him alive on May 27 1945  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>31</u>	<u>5</u>	<u>5</u>	hr. _____ min. _____

Immediate cause of death Pulmonary tuberculosis Duration about 2 yrs.

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

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

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

10. Usual occupation Farming

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

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

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

Of autopsy 12/26

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Henry C. Hollis

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

14. Maiden name Sarah Ann Gault

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

16. (a) Informant E. Michael, Record Clerk

(b) Address Mo. State Sanatorium Mount Vernon

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Janeshart Ark

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

(b) Address Janeshart Ark

19. (a) 5/29/45 (Date received local registrar) (b) Andy Gouford (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 \_\_\_\_\_

(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) (c) Means of injury \_\_\_\_\_

23. Signature U. L. Kinkawa (M. D. or other) m.d.

Address mt Vernon, Mo Date signed 5/27/45

1239

RECEIVED  
District Health Officer No. 6,  
District File Number 645-674  
Date Filed JUN 8 1945

APR 26 1952

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 Hugh H. Howard

Licensed Embalmer No. 3959

P. O. Address Levittown Ark

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.