

S. No. 2
DM-5-43
v. 5-17-39
I X36671

1954

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2461

REGISTRATION DISTRICT NO. 179

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 21 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3140 Main Street 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HOLLOWAY, Eugene E.
3. (b) If veteran, name war World War 1
3. (c) Social Security No. 500-12-7639

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June, Day 8, Year 1945
hour 6:30 pm

4. Sex: male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elizabeth Holloway
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased July 3 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 6 1945 to June 8 1945
that I last saw him alive on June 8 1945 and that death occurred on the date and hour stated above

8. AGE: Years Months Days If less than one day
56 11 5 hr. min.

Immediate cause of death Coronary occlusion 3 days
Due to arterio sclerosis

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

Other conditions none
(Include pregnancy within 3 months of death)
Major findings: 940
Of operations _____
Of autopsy no

10. Usual occupation Clerk

11. Industry or business _____

12. Name John Holloway

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

14. Maiden name Sally Ware
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Elizabeth Holloway
(b) Address 21 E 30th St

17. (a) removal (b) Date thereof 6/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Frank W. Paben Co.
(b) Address 20 West Linwood

19. (a) 6-9-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

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)
(c) Means of injury 0
23. Signature MR. C. B. Biebert (Print name or other)
Address 4000 Ballwin Ave Date signed 6/9/45

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

8 vol

JUN 28 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 Charles M. Quirk

Licensed Embalmer No. 3774

P. O. Address 20 W. Linwood

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.