

**FILED DEC 6 1945**

Registration District No. **172**

Primary Registration District No. **5642**

1. PLACE OF DEATH:

(a) County **Lafayette** *Middleton Township*  
(b) City or town **Rural (Waverly, Mo.)**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette** **574**  
(c) City or town **Rural (Waverly, Mo.)**  
(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 **James Allen Hollis**

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

4. Sex **Male (1)** 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 **12 25 1858**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**86 10 15** hr. min.

9. Birthplace **Chillicothe, Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

MOTHER FATHER { 12. Name **James Harvey Hollis**  
13. Birthplace **Chillicothe, Ohio**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Velary McPheters**  
15. Birthplace **Chillicothe, Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter Hollis**

(b) Address **Waverly, Missouri.**

17. (a) **Burial** (b) Date thereof **11/12/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Waverly Cemetery.**

18. (a) Signature of funeral director **W. H. Bremer**

(b) Address **Alma, Mo.**

19. (a) **Nov. 12-1945** (b) **Clayton T. Landrum**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **10**  
year **1945** hour **2 p.m.** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **11-3**, 19**45** to **11-10**, 19**45**  
that I last saw him alive on **11-10**, 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis chronic**

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

Other conditions **Pneumonia - Lobar** **8 days**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **908**  
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 **Geo A Kelling** (M. D. or other) **U**  
Address **Waverly Mo.** Date signed **11-11-45**

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

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed ..... 12-4-41

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.....



Licensed Embalmer No. 2696.

P. O. Address..... Alma, 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.