

FILED JAN 8 1946
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1314

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)
In this community 1 day

3. (a) PRINT

FULL NAME Ray Holland

3. (b) If veteran, name war None

3. (c) Social Security No. None

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 August 10 1912
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 3 28 hr. min.

9. Birthplace New Market Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Samuel M. Holland

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

14. Maiden name Lesra Cunning

15. Birthplace New Market Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Holland

(b) Address Blockton, Iowa

17. (a) removal (b) Date thereof 12/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City, Mo.

18. (a) Signature of funeral director Walter R. Bule & Co.

(b) Address 319 So. 10th Street,

19. (a) Dec 12 1945 (b) H. J. Mathews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9th
year 1945 hour 9 minute 40 A. M.

21. I hereby certify that I attended the deceased from Dec. 7 1945 to December 8 1945,
that I last saw him alive on Dec. 7, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death:
Heart Disease, rheumatic
Mitral insufficiency and stenosis

Due to _____
Due to _____

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

?

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 W. J. Bule (M. D. or other)
Address St. Joseph 8, Mo. Date signed 12/10

Dr. H. W. Carter

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 8 Dec
....., Registered Apprentice No. ✓
working under my personal supervision.

Signed Harold Bowman

Licensed Embalmer No. 3619

P. O. Address St. Joseph, 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.