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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4638

State File No. _____

FILED MAR 8 1946
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 150

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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 28 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph /
(If outside city or town limits, write "RURAL")
(d) Street No. 609 1/2 Messanie St 7
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Gus Holloway

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 11, 1872
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 21 If less than one day hr. _____ min. _____

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

10. Usual occupation Bartender

11. Industry or business unknown

MOTHER FATHER } 12. Name _____
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown 7
15. Birthplace unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant Social Security records
(b) Address Patee Hall, St. Joseph, Mo.
17. (a) Burial (b) Date thereof 2-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Barry Funeral Home
(b) Address St. Joseph, Mo.

19. (a) Feb. 15, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 2
year 1946 hour 9 minute 46 P. M.

21. I hereby certify that I attended the deceased from January 30,
19 33 to February 2 19 46
that I last saw him alive on February 2 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 days
Arteriosclerosis
Due to Arteriosclerosis 10 yrs.

Due to Senile Dementia 1 yr.

Other conditions (Include pregnancy within 3 months of death)
None

PHYSICIAN
Major findings: Of operations _____
Of autopsy [Signature]
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 _____

23. Charles H. Kemmer (M. D. or other) 0
Address Kirkpatrick Bldg. Date signed 2-8-46

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

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

Mollie E. Sidenfaden

Licensed Embalmer No.

4235

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.