

2-43
5-17-39
X35697

FILED MAR 14 1946
Registration District No. _____

Primary Registration District No. 4099

State File No. _____

Registrar's No. 33

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Pleasant Hill
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____
In this community 4 months
years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County 999
(c) City or town Pleasant Hill
(If outside city or town limits, write "RURAL") 16
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No) 21
If yes, name country _____

3. (a) PRINT FULL NAME John Howard Holloway
3. (b) If veteran, name war _____
3. (c) Social Security No. 511-12-1795

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 26
year 1946 hour 12 minute 45 P.M.
21. I hereby certify that I attended the deceased from _____
_____ 19 _____ to _____ 19 _____

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mana L. Holloway 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased Nov. 7 1888
(Month) (Day) (Year)

that I last saw h _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death Fracture of skull Duration _____
7 skull

8. AGE: Years 65 Months 3 Days 23
If less than one day _____ hr. _____ min.

Due to was struck by
fall on rock crusher
Due to _____

9. Birthplace Waverly, Pike Co. Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name John Holloway
13. Birthplace Unknown Mo. 0
(City, town or county) (State or foreign country)
14. Maiden name Sarah Ware
15. Birthplace Unknown Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mana L. Holloway

(b) Address Pleasant Hill

17. (a) Revised Removal Date thereof _____
(Special exemption or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centerville, Mo.

18. (a) Signature of funeral director W. J. French

(b) Address Pleasant Hill

19. (a) Mar. 2 - 1946 (b) Dorcas Jones
(Date received local registrar) (Registrar's signature)

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations 176 11
Of autopsy _____
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) Accident 19
(b) Date of occurrence Feb 26 1946
(c) Where did injury occur? Public Coal Crusher
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Coal Crusher
(Specify type of place) (e) Means of injury _____
While at work? _____
23. Signature E. M. Luff (M. D. or other) _____
Address Harrodsburg Date signed 2/26/46

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

MAR 19 1948

DEC 11 1956

MAR 2 1948

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 *J. Virgil Herrick*
Licensed Embalmer No. *3599*
P. O. Address *Pleasant Hill*

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.

Registration District No. 59

Primary Registration District No. 4099

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Leas
(b) City or town Pleasant Hill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME John H. Holloway

3. (b) If veteran, name war..... 3. (c) Social Security No. 5-11-12-1799

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Nov (Month) 1923 (Day) 1923 (Year)

8. AGE: Years 63 Months 11 Days 23 If less than one day, hr. min.

9. Birthplace Waverly, Pike Co, Ohio (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3-25-46 (Date received local registrar) (b) Rama J. Jones (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to.....
that I first saw him..... and that death occurred on the date and hour stated above.
immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings:
Of operations.....

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..... (M. D. or other)

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

4889