

FILED DEC 17 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10459**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Deaconess Hospital**
(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 **Ocie Hollingsworth**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Huston Hollingsworth** 6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **November 14 1908**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 0 22 hr. min.

9. Birthplace **Hornbeak Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **William G. McCord**

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

14. Maiden name **Fannie Unknown**

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

16. (a) Informant **William H. McCord**

(b) Address **5861 Plymouth Ave.**

17. (a) **Removal** (b) Date thereof **12-6-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hornbeak, Tennessee**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **DEC 6 1946** (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Tennessee** (b) County **Obion**
(c) City or town **Hornbeak**
(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 **Dec.** day **6**
year **1946** hour **9** minute **9**

21. I hereby certify that I attended the deceased from **10-9-1946**
19____ to **12-6** 19____
that I last saw her alive on **12-5** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Embolus**
No Pregnancy

Due to **abdominal surgery**
Due to **operation for colostomy on 2nd colon**

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?
(d)

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Joslyn** (M. D. or other) **M.D.**
Address **3903** Date signed **12-6-46**

REPEAT - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

NR-1
0
2

Joslyn

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. Allen Davis

Licensed Embalmer No.....

4053

P. O. Address.....

St. Louis, 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.