

FILED APR 17 1947
 Registration District No. **337**

Primary Registration District No. **4497**

Registrar's No. **34**

1. PLACE OF DEATH:
 (a) County **Shelby**
 (b) City or town **Clarence**
 (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 years, months or days) **Entire Life**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Shelby**
 (c) City or town **Clarence**
 (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 _____

3. (a) PRINT FULL NAME **JAMES OSBORN HOLLAND**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. **1**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **March** day **28th**
 year **1947** hour **5:00** minute **15 P.M.**

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

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

7. Birth date of deceased: **Sept 21 1929**
 (Month) (Day) (Year)

Immediate cause of death: **Strangulation**

8. AGE: Years **17** Months **6** Days **7** If less than one day hr. _____ min. _____

Due to **Becoming entangled in rope while exercising in his own private gymnasium**
 Due to **Strangulation**

9. Birthplace **Clarence Mo**
 (City, town, or county) (State or foreign country)

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

10. Usual occupation **Student**

Major findings: Of operations **1954**

11. Industry or business _____

Of autopsy _____

12. Name **Franklin O. Holland**

PHYSICIAN _____

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

Underline the cause to which death should be charged statistically.

14. Maiden name **Buchak Ragland**

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

16. (a) Informant **Dr. F. O. Holland**

(b) Address **Clarence Mo**

17. (a) **Burial** (b) Date thereof **3-30-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maplewood-Clarence**

18. (a) Signature of funeral director **G. E. Haggard**

(b) Address **Clarence Mo**

19. (a) **April 27 47** (b) **W. Th. Gage**
 (Date received local registrar) (Registrar's Signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accidental 1620**

(b) Date of occurrence **March 28 1947**

(c) Where did injury occur? **Clarence Shelby Mo.**
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In basement of home

While at work? **Exercise** (Specify type of place) (e) Means of injury **Strangulation**

23. Signature **W. Th. Gage** **Coroner**

Address **Bethel, Mo** Date signed **3/28/47**

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

JAN 21 1939

Director of Health Officer No. 10
File Number 447-218
Date Filed APR 15 1947

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 James C. Hopper
Licensed Embalmer No. 476
P. O. Address Clarence, 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.