No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 29 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33564

Registration District No. 1 | Primary Registration District No. 3000 | Registrar's No. 284

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: One year, two weeks (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Adair
(c) City or town: Greentop
(If outside city or town limits, write "RURAL")
(d) Street No.: R. R.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Julia Holloway
3. (b) If veteran, name war:
3. (c) Social Security No.: None

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Sam Holloway
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept. (Month) 5 (Day) 1860 (Year)

8. AGE:

Years	Months	Days	If less than one day
87	1	7	hr. min.

9. Birthplace: Chillicothe (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Home
11. Industry or business:
MOTHER FATHER
12. Name: John McCollum
13. Birthplace: Kentucky (City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Marion Holloway
(b) Address: Greentop, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/17/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Maple Hills Cmt.
18. (a) Signature of funeral director: Dee Riley
(b) Address: Kirksville, Missouri
19. (a) Oct 20-47 (Date received local registrar) (b) Nate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct day: 11
year: 1947 hour: 6 minute: 4 A.M.
21. I hereby certify that I attended the deceased from Feb 6 1947 to Oct 11 1947
that I last saw her alive on Oct 10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	instant
Due to: Hypertension	years
Due to: Arteriosclerosis	years
Other conditions: Senility (Include pregnancy within 3 months of death)	years

Major findings:
Of operations: 83A
Of autops.:

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: M. T. Gutenschn (M.D. or other) DO
Address: Kirksville, Mo. Date signed: 10-11-47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 10
District File Number 10-47-1452
Date Filed OCT 27 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 O E Riley

Licensed Embalmer No. 4181.

P. O. Address Kirksville, 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.