

No. 2
343
17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3673

State File No.

FILED FEB 3 1948

Registration District No.

Primary Registration District No. 6127

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Eminence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Main St. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether)

In this community 65 900
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon

(c) City or town Eminence
(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

3. (a) PRINT FULL NAME James Henry Holloway

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-15 day 18-48
year..... hour..... minute..... M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased July 27 1862
(Month) (Day) (Year)

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

8. AGE: Years Months Days If less than one day

86 5 22 hr. min.

Immediate cause of death apoplexy

Due to.....

Due to.....

9. Birthplace Rocky Fork Hautsdsale Boone Co.
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) g37

Major findings: Of operations.....

Of autopsy.....

10. Usual occupation Laborer & Farmer

MOTHER FATHER

11. Industry or business.....

12. Name Henry Holloway

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

14. Maiden name Jane Harris

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Emmett Searcy

(b) Address Eminence

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

(c) Place: burial or cremation Boone Eminence, Mo

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?.....

18. (a) Signature of funeral director J. Burns

(b) Address Willow Springs Mo.

19. (a) 1-23-48 (b) Med. Rec.
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature Frank Hyde (M. D. or other)

Address Eminence Date signed 1-19-48

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

RECEIVED

District Health Officer No. 5.

District File Number 1A. 879.

Date Filed 1-24-48

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.....

J. Wm. Barnes....., Registered Apprentice No. 413
working under my personal supervision.

Signed.....

J. Wm. Barnes
Licensed Embalmer No. 3379

P. O. Address Willow Springs, 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.

Registration District No. *336*

Primary Registration District No. *6128*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Shannon*
(b) City or town *Eminence*
(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 *60 years* years, months or days)

3. (a) PRINT FULL NAME *James C. Holloway*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *wid*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: *July 2* (Month) *1904* (Day) *1904* (Year)

8. AGE: Years *86* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation *laborer, farmer*

11. Industry or business _____

MOTHER FATHER
12. Name *Henry Holloway*
13. Birthplace *Boone County, Mo.* (City, town or county) (State or foreign country)
14. Maiden name *Jane Norris*
15. Birthplace *Boone County, Mo.* (City, town, or county) (State or foreign country)

16. (a) Informant *Emmett Searcy*
(b) Address *Eminence, Mo*
17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *11/19/48* (Month) (Day) (Year)
(c) Place: burial or cremation *Eminence Mo*

18. (a) Signature of funeral director *JCB Irms*
(b) Address *Willow Springs, Mo.*
19. (a) *1-10-49* (Date received local registrar) (b) *Walter Peck* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Shannon*
(c) City or town *Eminence* (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1948* hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him alive on _____, 19____; 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) _____
Date signed _____

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

STUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1948

5-3673