S. No. 300
M—10-47
v. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 23 1948
Registration District No. 3777

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35130
Primary Registration District No. 4467
Registrar's No.

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

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Valley Park
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Moll Nursing Home. 4
(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) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: Valley Park
(If outside city or town limits, write "RURAL")
(d) Street No.: Moll Nursing Home.
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: John Thomas Holman
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: Belle Holman
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: February (Month) 25 (Day) 1863 (Year)
8. AGE: Years 85 Months 7 Days 19 If less than one day ____ hr. ____ min.
9. Birthplace: Caledonia (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business ____
FATHER 12. Name: John B. Holman
FATHER 13. Birthplace: Tennessee (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Lucy Ann McTurrey
MOTHER 15. Birthplace: Missouri (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Minnie Howard
(b) Address: 5887 Cabanne Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-16-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Stone Hill, Mo.
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
19. (a) 10-15-48 (Date received local registrar) (b) Cecil A. Sharp, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14 year 1948 hour 5 minute 45 A.M.
21. I hereby certify that I attended the deceased from Oct 12, 1948, to Oct 14, 1948, that I last saw him alive on Oct 14, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemiplegia Rt	5 da
Due to: Hypertensive Cardiovascular disease	Chr
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations ____
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) ____
(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: [illegible] (M. D. or other) MD
Address: Webster Groves Mo Date signed 10-15-48

(Licensed Embalmer's Statement on Reverse Side)

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. G W Wilkinson

Licensed Embalmer No. 3575

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.