

FILED NOV 16 1948

Registration District No. 37

Primary Registration District No. 3023

Registrar's No. 231

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wetzel Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 2 days
years, months or days

3. (a) PRINT

FULL NAME Robert Anson Holladay

3. (b) If veteran, name war no 3. (c) Social Security No. 494-12-0485

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ida Holladay 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased July 28 1876
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 10 If less than one day hr. min.

9. Birthplace Carl Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farm

12. Name William Halladay

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

14. Maiden name Martha Warner

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

16. (a) Informant Mrs. Ida Halladay

(b) Address Oceola, Missouri

17. (a) Burial (b) Date thereof Nov. 10, 1948
(Burial, cremation, or otherwise) (Month) (Day) (Year)

(c) Place: burial or cremation Oceola Cemetery

18. (a) Signature of funeral director F. B. Goodrich

(b) Address Oceola, Missouri

19. (a) 11-8-48 (b) R. R. Kennedy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair 93
(c) City or town Oceola 2
(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 Nov day 8
year 1948 hour 1 minute 45 P. M.

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.

Immediate cause of death generalized peritonitis following rupture of gastric ulcer
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 159

Major findings: Of operations perforated ulcer & lesser curvature of stomach
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? _____

While at work? (Specify type of place) _____ (e) Means of injury 1

23. Signature Gus West (M. D. or other) X

Address Clinton Mo Date signed 11-8-48

RECEIVED

District Health Officer No.

District File Number 19-42-18

Date Filed 11-15-40

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 F B Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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.