

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4945
433

BIRTH NO. 48-37763 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BATES		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (In this place) 1 MO. 24d.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ADRIAN		9
d. FULL NAME OF HOSPITAL OR INSTITUTION THE CHILDREN'S MERCY HOSPITAL			d. STREET ADDRESS (If rural, give location) 1		

3. NAME OF DECEASED (Type or Print) a. (First) RONNIE b. (Middle) DUANE c. (Last) HOLLENBECK			4. DATE OF DEATH (Month) (Day) (Year) JANUARY 30 1949		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH July 20, 1948	9. AGE (In years last birthday) 6 MO. 10		IF UNDER 1 YEAR: Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Butler, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME ROBERT Hollenbeck		13b. MOTHER'S MAIDEN NAME NANCY MUDD		14. NAME OF HUSBAND OR WIFE			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Nancy Mudd; R.R.#2, Adrian, Mo.					
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Embolic event.					INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					581.0	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?				
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE E.O.H. Schmidt (Date of title)		23b. ADDRESS THE CHILDREN'S MERCY HOSPITAL		23c. DATE SIGNED 30-1-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-30-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Adrian Mo.		
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DATE REC'D BY LOCAL REG. 1-30-49	REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Creath & Co. Adrian Mo.		
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.