

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21175

State File No.

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **5491**

| | | | | | | | |
|---|------------------------------|---|---|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 5491 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) St Louis | | c. LENGTH OF STAY (In this place) 65 days | | c. CITY (If outside corporate limits, write RURAL and give township) St Louis | | 17 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 1124^a So. 9th Street | | | | d. STREET ADDRESS (If rural, give location) 1124^a So. 9th Street | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) SIDNEY | | b. (Middle) FRANCES | | c. (Last) HOLLOMAN | |
| 4. DATE OF DEATH | | (Month) (Day) (Year) | | June 23 - 1949 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W | | 8. DATE OF BIRTH OCT-9-1871 | | 9. AGE (In years last birthday) Months Days Hours Min. 77 8 14 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? _____ | |
| 13a. FATHER'S NAME Tom CAVANDER | | | 13b. MOTHER'S MAIDEN NAME unknown | | | 14. NAME OF HUSBAND OR WIFE William | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruth Chambers 1124^a So 9th St. | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Debility | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE SUICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) 930 | | | |
| 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? 11/23/49 | | | |
| 22. I hereby certify that I attended the deceased from 6-20-1949 , to 6-23-1949 , that I last saw the deceased alive on 6-23-1949 , and that death occurred at 5:30 p. m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE E. J. Kloppel, Jr. (Degree or title) _____ | | | | 23b. ADDRESS 905 Morrison Ave. | | 23c. DATE SIGNED 6-25-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 6/27/49 | | 24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK | | 24d. LOCATION (City, town, or county) (State) St Louis County Mo. | |
| DATE REC'D BY LOCAL REG. JUN 26 1949 | | REGISTRAR'S SIGNATURE J. P. Kauter | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Allen H. McLaughlin 5501 Lafayette | | | |

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

Mr C F Kloepfel
905 Morrisonville

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 J R Cooper

Licensed Embalmer No. 3638

P. O. Address 2301 Kefauver

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.