

FILED DEC 6 1949
#94295

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38837
State File No. 10113
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		e. STREET ADDRESS (If rural, give location) 1011 Morrison Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) ANDREW	b. (Middle)	c. (Last) HOLLOWAY	4. DATE OF DEATH (Month) (Day) (Year) December 21, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 5 - 1902	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	10b. KIND OF BUSINESS OR INDUSTRY Send & Travel Co	11. BIRTH PLACE (State or foreign country) Penn.	12. CITIZEN OF WHAT COUNTRY? U. S. A
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13a. FATHER'S NAME Jack Holloway	13b. MOTHER'S MAIDEN NAME Isha	14. NAME OF HUSBAND OR WIFE Myrtle Holloway	Divorced
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Alta Nichols	ADDRESS Tortaguilla 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia of lungs		INTERVAL BETWEEN ONSET AND DEATH Feb 49
	ANTECEDENT CAUSES Morbidity 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? H9 123 X
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22. I hereby certify that I attended the deceased from 3/24/49 to 11/21/49, 1949, that I last saw the deceased alive on 11/21/49, 1949 and that death occurred at 11:00 AM, from the causes and on the date stated above.

23a. SIGNATURE Joseph P. Alden M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 11/21/49
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24a. BURIAL, CREMATION (REMOVAL) (Specify)	24b. DATE 11/25/49	24c. NAME OF CEMETERY OR CREMATORY Foe Fee Cemetery	24d. LOCATION (City, town, or county) (State) Tattonville Mo
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DATE REC'D BY LOCAL NOV 25 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Bourneau Brothers Inc	ADDRESS Overland Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 3454

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland

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.