

FILED MAY 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12158**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **138**

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fulton</b>	c. LENGTH OF STAY (in this place) <b>10 months</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Guthrie</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Shoof Home</b>		d. STREET ADDRESS (If rural, give location) <b>0148</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>James</b> b. (Middle) <b>Ridgway</b> c. (Last) <b>Holladay</b>			4. DATE OF DEATH (Month) <b>4</b> (Day) <b>24</b> (Year) <b>1950</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>12-3-1869</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b>	IF UNDER 11 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Stephens Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>Mo</b>

13a. FATHER'S NAME <b>Joseph Holladay</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Ayle</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Robert Holladay</b>		ADDRESS <b>Fulton Mo RR #6</b>

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		INTERVAL BETWEEN ONSET AND DEATH  <b>7230</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arthritis Deformans</b>		
	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.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-22-1950**, to **4-24-1950**, that I last saw the deceased alive on **4-22-1950** and that death occurred at **4:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W O Payne</b>		(Degree or title) <b>MD</b>		23b. ADDRESS <b>R#6 Fulton Mo</b>		23c. DATE SIGNED <b>4/25/50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 26-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Boydsville Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Callaway Co. Mo</b>		
DATE REC'D BY LOCAL REG. <b>April 25-1950</b>	REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>		426		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wallace Funeral Home</b>	ADDRESS <b>Fulton Mo</b>

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

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RECEIVED MAY 2 1950  
District Health Officer No. 9,  
District File Number

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 Wesley C. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton, Md

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.