

FILED DEC 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36207

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1380

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Atchison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 1 day	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rockport 0030	
		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print) a. (First) Wayman b. (Middle) Ray c. (Last) Holliway			4. DATE OF DEATH (Month) (Day) (Year) Dec. 3, 1950			
5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 27, 1878	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY common	11. BIRTHPLACE (State or foreign country) Rockport, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Holliway	13b. MOTHER'S MAIDEN NAME Alice Maupin	14. NAME OF HUSBAND OR WIFE Mary Holliway
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Holliway, Rockport, Mo.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Contusions, Lacerations		18 hrs
	ANTECEDENT CAUSES Subarachnoid Hemorrhage Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Basal Fracture of skull		18 hrs
DUE TO (b)			
DUE TO (c)		2 1/2	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			25

19a. DATE OF OPERATION 12/3/50	19b. MAJOR FINDINGS OF OPERATION Cerebral Edema; Subarachnoid Hemorrhage	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Rockport Atchison Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12 2 50 P.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Allegedly Struck by Automobile

22. I hereby certify that I attended the deceased from 12-2-50, 1950, to 12-3-50, 1950, that I last saw the deceased (Give on 12-3, 1950, and that death occurred at 10:20 A.M.; from the causes and on the date stated above.

23a. SIGNATURE John R. McDaniel (Degree or title) M.D.	23b. ADDRESS 902 Edmund St., St. Joseph Mo.	23c. DATE SIGNED 12-4-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Dec. 3, 1950	24c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	24d. LOCATION (City, town, or county) (State) Rockport, Missouri
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DATE REC'D BY LOCAL REG. Dec 8, 1950	REGISTRAR'S SIGNATURE Carl E. Carter	25. FUNERAL DIRECTOR'S SIGNATURE Neater-Bourman Funeral Home	ADDRESS St. Joseph, Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

1107

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MS
OCT 18 1961

Dr. Joseph R. McDevitt

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.

Signed *Eugene Wood*

Signed _____
Student Embalmer

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St. Joseph

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.