

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 30 1952

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>29</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u>		c. LENGTH OF STAY (in this place) <u>7 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u>		<u>0-13</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grim-Smith Memorial</u>				d. STREET ADDRESS (If rural, give location) <u>112 E. Buchanan</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Epp</u>		b. (Middle) <u>S.</u>		c. (Last) <u>Holloway</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23, 1952</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 17, 1884</u>	
9. AGE (In years last birthday) <u>67</u>		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) <u>Pharmacist, Rtd.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacist, Rtd.</u>		11. BIRTHPLACE (State or foreign country) <u>Kirkville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J. R. Holloway</u>			13b. MOTHER'S MAIDEN NAME <u>Louisa Hoag</u>			14. NAME OF HUSBAND OR WIFE <u>Forest Friday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-05-8134</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Forest Holloway, Kirkville, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic endocarditis and Myocarditis</u>  INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Chronic nephritis</u>  INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4214</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 <u>Jan</u> , 19 <u>48</u> , to <u>Jan 23</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>Jan. 23</u> , 19 <u>52</u> , and that death occurred at <u>2:30 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Spencer L. Freeman M.D.</u> (Degree or title)				23b. ADDRESS <u>Kirkville, Mo.</u>		23c. DATE SIGNED <u>1-24-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/25/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green City</u>		24d. LOCATION (City, town, or county) (State) <u>Green City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-26-52</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Paul M. Kelly Kirkville, Mo.</u>			

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

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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 *Juan C. Cooper*

Licensed Embalmer No. *4119*

P. O. Address *Starksville, Mo.*

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.