

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10102**
Registrar's No. **2064**

FILED MAR 24 1952

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 Illinois b. COUNTY Jads	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Elk Township	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) RR # 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) BERNICE	b. (Middle) NMN	c. (Last) HOLLIDAY	2/29 29 52		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 12-17-1918		9. AGE (In years last birthday) 33
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Alto Pass, Illinois		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Albert Stone	13b. MOTHER'S MAIDEN NAME Melvina Rendleman	14. NAME OF HUSBAND OR WIFE Homer Lee Holliday
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Homer L. Holliday, Elkhville, Ill.	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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CHRONIC MYELOGENIC LEUKEMIA		
	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 checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 20 ft. fall
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22. I hereby certify that I attended the deceased from **2/18**, 19**52**, to **2/29**, 19**52**, that I last saw the deceased alive on **2/29**, 19**52**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE F. R. Bradley (Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 3/1/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 3-2-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) DuQuoin, Illinois
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DATE REC'D BY LOCAL REG. MAR 4 1952	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Schroeder, DuQuoin, Illinois	ADDRESS
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Ben Hoffman*

Licensed Embalmer No. 4366

P. O. Address

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.