

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31320

State File No.

0396
OCT 6 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 891

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> <i>0316</i>	
c. LENGTH OF STAY (In this place) <u>4 hours</u>		d. STREET ADDRESS (If rural, give location) <u>2901 N. Grant Avenue</u> <i>U</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>	b. (Middle) <u>ETTA</u>	c. (Last) <u>HOLLOWAY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 1, 1952</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6 Sept. 1869</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Alterationer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Merchantile Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hermitage, Missouri</u> <i>0</i>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Rev. Samuel Lopp</u>	13b. MOTHER'S MAIDEN NAME <u>Isabelle Darby</u>	14. NAME OF HUSBAND OR WIFE <u>John Harry Holloway</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>491-14-4051</u>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs. W.A. Broyles, 2901 N. Grant Avenue, Springfield, Mo.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolism, recurrent</u>		
	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 <u>332X</u>	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 1, 1952 to Oct 1, 1952 that I last saw the deceased alive on Oct 1, 1952 and that death occurred at 1:30P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm J Silsby MD</u>	23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>10-2-52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4 Oct. 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>10-2-52</u>	REGISTRAR'S SIGNATURE <u>Deputy Frank Williamson Registrar</u>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Frank C. Thomas, Springfield, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Call when signs & we will send for this!

JUL 9 1953

OCT 7 1953

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 Ralph H. Luten

Licensed Embalmer No. 2899

P. O. Address Springfield, Missouri.

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.