

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

27718

State File No. ....

 BIRTH NO. SEP 8-1953 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 237

1. PLACE OF DEATH a. COUNTY <u>BOONE</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>Columbia</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ELLIS FISCHER STATE CANCER HOSP.</u>				e. STREET ADDRESS (If rural, give location) <u>1331 KIMBROUGH</u> <u>0396</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JACK</u> b. (Middle) <u>MATHEW</u> c. (Last) <u>HOLLOWAY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9</u> <u>2</u> <u>53</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>3</u>		8. DATE OF BIRTH <u>11-14-12</u>			
9. AGE (In years last birthday) <u>40</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u>		IF UNDER 1 HR. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>WILLOW SPRINGS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>CHARLES HOLLOWAY</u>			13b. MOTHER'S MAIDEN NAME <u>LUCILE SCANLON</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL RECORDS</u>		ADDRESS			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of R. Lung</u> ANTECEDENT CAUSES <u>C Metastases</u> DUE TO (b) <u>C Metastases</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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 <u>Sep 2</u> , 1953, to <u>Sep 2</u> , 1953, that I last saw the deceased alive on <u>Sep 2</u> , 1953, and that death occurred at <u>4:20</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>William Sweeney M.D.</u>				23b. ADDRESS <u>Ellis Fisher Cancer Hosp</u>		23c. DATE SIGNED <u>Sep 2 53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9-3-1953</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Sept 3 1953</u>		REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Service</u>		ADDRESS <u>Columbia Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. *4887*

P. O. Address *Columbia, W. Va.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.