

FILED JUN 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18731

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. K2

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fayette, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fayette, Rural, Booneslick Twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lee Hospital		d. STREET ADDRESS (If rural, give location) R. R. # 2 0450	

3. NAME OF DECEASED (Type or Print) a. (First) Beatrice b. (Middle) Davis c. (Last) Hollon			4. DATE OF DEATH (Month) (Day) (Year) May 27, 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 4/28/1895		9. AGE (In years last birthday) 59		IF UNDER 1 YEAR (Month) (Day) (Hours) (Min.) 0 29	
10a. USUAL OCCUPATION (Give kind of work done during usual working hours if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Howard County, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Aeriel Jennings		13b. MOTHER'S MAIDEN NAME Effie Davis Head		14. NAME OF HUSBAND OR WIFE George L. Hollon	
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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 ADDRESS Homer Jennings R.R. 2 Fayette, Mo.	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma breast 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.				INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
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19a. DATE OF OPERATION 1949		19b. MAJOR FINDINGS OF OPERATION 170 X				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) (Min.)		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 **1949** to **May 27, 1954**, that I last saw the deceased alive on **May 27, 1954** and that death occurred at **8:20 p.m.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. K. Shell		23b. ADDRESS Fayette, Mo.		23c. DATE SIGNED 6/2/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/29/1954		24c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	
				24d. LOCATION (City, town, or county) (State) New Franklin, Missouri	

DATE REC'D BY LOCAL REG. 6-2-54		REGISTRAR'S SIGNATURE Mary K. Shell #36		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph A. Carr Fayette, Missouri	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 4 1954

JUN 2 1954

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

Ralph A. Carr

Signed.....

Student Embalmer

Licensed Embalmer No. *3340*

P. O. Address *Fayette, 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.