

REC'D OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30629

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4198

1. PLACE OF DEATH a. COUNTY JACSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACSON	
b. CITY OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 15 YRS.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2120 TRACY AVE.		e. STREET ADDRESS (If rural, give location) 25 1902 E. 14TH ST. 2 25 0	

3. NAME OF DECEASED (Type or Print) ETHEL HOLLOWAY			4. DATE OF DEATH SEPT. 1, 1954		
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH FEB. 22, 1892		9. AGE (In years last birthday) 62		10. UNDER 1 YEAR Months Days	
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 (City and State or Foreign Country) LEXINGTON, MO.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME WILLIAM MCKINNEY		13b. MOTHER'S MAIDEN NAME MARGARET SNELL	
14. NAME OF HUSBAND OR WIFE JOHN HOLLOWAY		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 JOHN COATES		18. ADDRESS 1721 PARK			

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		MEDICAL CERTIFICATION Hypertensive type heart disease Generalized arteriosclerosis Acute Coronary disease Atherosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19. INTERVAL BETWEEN ONSET AND DEATH 4201	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? none	

22. I hereby certify that I attended the deceased from 8-25-1954 to 9-1-1954, that I last saw the deceased alive on 9-1-1954 and that death occurred at 10:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE J. S. Wells, M.D.		(Degree or title) M.D.		23b. ADDRESS 2122 - E - 15th St	
23c. DATE SIGNED 9-2-54		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE SEPT. 4, 1954	
24c. NAME OF CEMETERY OR CREMATORY HINCHOLD CEMETERY		24d. LOCATION (City, town, or county) Kansas City		(State) MO.	
DATE REC'D BY LOCAL REG. 9-2-54		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Fannie T. Meek	
				ADDRESS Kansas City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
J. S. Wells, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Fannie L. Meek.....

Licensed Embalmer No. 3819..

P. O. Address Kansas C.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.