

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39595**

FILED DEC 2 1954

BIRTH NO. **13420-54** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **2650**

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Richmond Heights</b>	c. LENGTH OF STAY (In this place) <b>1 month</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Mary Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>3020 Cherokee 2741</b>	
3. NAME OF DECEASED a. (First) <b>Dennis</b> b. (Middle) <b>Muriel</b> c. (Last) <b>Hollinsworth</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 9 1954</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Oct. 5 1954</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>1</b> <input type="checkbox"/> MONTHS <b>4</b> <input type="checkbox"/> HOURS <b>4</b> <input type="checkbox"/> MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Willard Hollinsworth</b>	
13b. MOTHER'S MAIDEN NAME <b>Blanche Lewis</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Willard Hollinsworth</b>		ADDRESS <b>St Louis Mo.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malnutrition (acute undernutrition)</b>		DUPLICATE		<b>1 week</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUPLICATE			
19a. DATE OF OPERATION <b>10-10-54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Obst. duodenum due to Congenital band</b>		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) <b>7620</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 **5<sup>th</sup> Oct**, 19**54**, to **9 Nov**, 19**54**, that I last saw the deceased alive on **8 Nov**, 19**54**, and that death occurred at **9:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Mary C. Hancock MD</b>	(Degree or title)	23b. ADDRESS <b>4660 Maryland</b>	23c. DATE SIGNED <b>9 Nov 54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11-11-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sturley Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Washington Co Mo.</b>
DATE REC'D BY LOCAL REG. <b>11/16/54</b>	REGISTRAR'S SIGNATURE <b>Hecheal K. Ambrose</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Luther Spain Peters MD</b>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. .

Student .....  
Signature of Student Embalmer

Signed *Murphy L. Sparks* .....

Licensed Embalmer No. *4258*

P. O. Address *Hatting* .....

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.