

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35547

State File No. \_\_\_\_\_

FILED NOV 10 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2515

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Manchester</u>		c. CITY OR TOWN <u>Times Beach?</u>	
c. LENGTH OF STAY (in this place) <u>10/28/55</u> days		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pine Crest Nursing Home Bldg 2</u>		e. STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED a. (First) <u>MARY</u> (Type or Print)		b. (Middle)	
c. (Last) <u>Holliday</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 28-55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 21 1895</u>
9. AGE (In years last birthday) <u>60 YRS</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	
IF UNDER 24 HRS. Hours <u>7</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Steine's Rest.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>DeKalb Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND/OR WIFE <u>David Holliday (Dec'd)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>494-05-2843</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Kenneth Cab</u>		ADDRESS <u>5424 Gilmore Ave</u>	
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) <u>CARCINOMATOSIS</u>  ANTECEDENT CAUSES DUE TO (b) <u>PRIMARY CARCINOMA</u> DUE TO (c) <u>OF CERVIX UTERI.</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>CHRONIC MYOCARDITIS</u>	
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>171X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>	
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>SEPT 1, 1955</u> , to <u>OCT. 25, 1955</u> , that I last saw the deceased alive on <u>OCT 28, 1955</u> , and that death occurred at <u>11 P</u> m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>B.R. Loving MD</u>		23b. ADDRESS <u>BALLWIN, MO</u>	
23c. DATE SIGNED <u>10-29-55</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>10-31-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN STYGAR and SON FUNERAL HOME</u>	
DATE REC'D BY LOCAL REG. <u>10-31-55</u>		ADDRESS <u>554 Riverview</u>	

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

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**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 *J. W. Rister*.....

Licensed Embalmer No. *39*..

P. O. Address *St. Louis*.....

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