

THE DIVISION OF HEALTH OF MISSOURI
 FILED JAN 26 1956 STANDARD CERTIFICATE OF DEATH

State File No. **2771**
 Registrar's No. **304**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3641 Bamberger Ave		e. STREET ADDRESS (If rural, give location) 3641 Bamberger Ave			
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) c. (Last) HOLLAND		4. DATE OF DEATH 1-9-1956		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 1-9-1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor		10b. KIND OF BUSINESS OR INDUSTRY Holland Furniture Co		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Michael Holland		13b. MOTHER'S MAIDEN NAME Emelie Sauerwein		14. NAME OF HUSBAND OR WIFE Clara Holland	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 489-34-6489		17. INFORMANT'S SIGNATURE OR NAME Clara Holland ADDRESS 3641 Bamberger Ave	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Lung ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute myocarditis DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 days 6 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) 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 **Jan 6, 1954**, to **Jan 9, 1956**, that I last saw the deceased alive on **Jan 9, 1956**, and that death occurred at **7:25 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Salisbury M.D.		23b. ADDRESS 3548 Sidney St		23c. DATE SIGNED 1-10-56	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-12-1956		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) 10160 Gravois Road Mo	
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DATE REC'D BY LOCAL REG. JAN 10 1956		REGISTRAR'S SIGNATURE Paul Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Ziegler ADDRESS 6409 Gravois Ave	
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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 e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Jan M. Lyons

Licensed Embalmer No.....4

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.