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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30908
STATE FILE NUMBER
1049
Registrar's No.

FILED OCT 7 1957

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY Wichita	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN Wichita Falls	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Central Police Sta.		d. STREET ADDRESS Not known	
3. NAME OF DECEASED (Type or print) First HURON Middle HORACE Last HOLLOWAY		4. DATE OF DEATH Month Sept. Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) Bartlesville Oklahoma
13a. FATHER'S NAME Charles F. Holloway		13b. MOTHER'S MAIDEN NAME Margaret Sallee	14. NAME OF HUSBAND OR WIFE None
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. 527-01-1663	17. INFORMANT Ralph Holloway
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA		INTERVAL BETWEEN ONSET AND DEATH 6 HOURS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DELEKUM TREMORS		2 HOURS	
DUE TO (c) _____		307X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Wichita Falls COUNTY _____ STATE _____	
21. I attended the deceased from SEPT. 29, 1957 to SEPT 29, 1957 and last saw ^{him} alive on SEPT. 29, 1957 Death occurred at 9:38A m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) James H. Baker, M.D.	
22b. ADDRESS 1302 FARMAN ST. JOSEPH, MISSOURI		22c. DATE SIGNED 10-1-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-1-57	23c. NAME OF CEMETERY OR CREMATORY Wichita Falls Cemetery	23d. LOCATION (City, town, or county) (State) Wichita Falls Texas
24. FUNERAL DIRECTOR Stoney Funeral Home		25. DATE RECD. BY LOCAL REG. Oct. 4, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *George A. Huebel*

Licensed Embalmer No. *4752*
 P. O. Address *St Joseph M*

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. *VE-1-01*
 If this body is not embalmed, fact should be so stated above.