

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1957

State File No. **33643**
Registrar's No. **8833**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1477 So. Vandeventer Ave		d. STREET ADDRESS (If rural, give location) 1477 Vandeventer Av.	
3. NAME OF DECEASED (Type or Print) a. (First) Thelma b. (Middle) Klaine c. (Last) Holoman		4. DATE OF DEATH (Month) (Day) (Year) 9/19/57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/15/04
9. AGE (In years last birthday) 53		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Indiana Harbor, Ind.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Thomas E. Conway		13b. MOTHER'S MAIDEN NAME Nettie Schaefer	
14. NAME OF HUSBAND OR WIFE James Holoman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 346-03-5801		17. INFORMANT'S SIGNATURE OR NAME Rev. Sill 4462 Norfolk Av.	
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure ANTECEDENT CAUSES DUE TO (b) Cerebro-Vascular Accident DUE TO (c) Panarteritis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes	
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) (Min.)		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 March , 1955, to Sept 19 , 1957, that I last saw the deceased alive on Sept 12 , 1957, and that death occurred at 5:00 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Robert W. Shelby		23b. ADDRESS D.O. 1917 N. Hanley Rd.	
23c. DATE SIGNED 9-19-57		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 9/23/57		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Bull Campbell Mort. 5165 Delmar Bl.	
DATE REC'D BY LOCAL REG. SEP 20 57		REGISTRAR'S SIGNATURE J. Carl Smith - mo	

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

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
Student Embalmer

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address St Louis Mo

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 this body is not embalmed, fact should be so stated above.