

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37591**
10161

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY ST. LOUIS, MO.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	c. LENGTH OF STAY (in this place) 16 d	c. CITY OR TOWN Chester	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hospital		STREET ADDRESS (If rural, give location) 32 812 S	

3. NAME OF DECEASED (Type or Print) a. (First) VIRGINIA b. (Middle) R. c. (Last) HOLLISTER			4. DATE OF DEATH (Month) (Day) (Year) 10 - 26 - 57		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH April - 7 - 1870	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and State or Foreign Country) Calloway Co., Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Thomas Harrison	13b. MOTHER'S MAIDEN NAME Catherine F. Maddox	14. NAME OF HUSBAND OR WIFE Charles
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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. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Clayborn Jackson, Mexico, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) coronary artery sclerosis		
		DUE TO (c) arteriosclerosis, generalize. gangrene of foot		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pericarditis. Endocardium et mural thrombus. Abd. aneurysm.		

19a. DATE OF OPERATION 10. 22. 57	19b. MAJOR FINDINGS OF OPERATION amputation, supracondylar, et. gangrene toes 420	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	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 **10-10**, 19**57**, to **10-26**, 19**57**, that I last saw the deceased alive on **10-26**, 19**57**, and that death occurred at **7:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Bern M Passanante, M.D.	23b. ADDRESS 1755 So Grand, St. L. Mo.	23c. DATE SIGNED OCT 29 57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-27-57	24c. NAME OF CEMETERY OR CREMATORY Old Aux Vasse Cemetery	24d. LOCATION (City, town, or county) (State) Aux Vasse, Mo.

DATE REC'D BY LOCAL REG. OCT 29 57	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

INTERNATIONAL ASSOCIATION OF EMBALMERS

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 *Robert M. Murray*

Licensed Embalmer No. *374*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.