

FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **931**

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Green</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Taney</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Hallister</u> <u>1060</u>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>P.O. Box</u>	
Length of stay in 1b <u>30a.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ann.</u> Middle <u>(Grand)</u> Last <u>Holliday</u>			4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1904</u>		9. AGE (In years last birthday) <u>54</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (City and state or country) <u>Cedar Creek, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>Anton Muller</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Pitts</u>		14. NAME OF HUSBAND OR WIFE <u>Sam. Holliday</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Sam. Holliday</u> Address <u>Hollister, MO.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Brain tumor?</u>	
	DUE TO (c) <u>pending pathological examination</u>	
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 checked="" type="checkbox"/> NO <input 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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Hollister</u>		COUNTY <u>MO.</u>		STATE	
21. I attended the deceased from <u>1-17-58</u> to <u>1-19-58</u> and last saw her alive on <u>1-19-58</u> Death occurred at <u>4:40</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John P. K. Haug, M.D.</u>					22b. ADDRESS <u>1636 S. Glenstone</u>			22c. DATE SIGNED <u>1-21-58</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-22-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Memorial Park Branson</u>		23d. LOCATION (City, town, or county) <u>MO.</u>		STATE	
24. FUNERAL DIRECTOR <u>Whelchel F. Home</u>			ADDRESS <u>Branson, MO</u>			25. DATE RECD. BY LOCAL REG. <u>1-22-58</u>		26. REGISTRAR'S SIGNATURE <u>Effie C. Melton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

VS
APR 29 1959

JUL 2 1962

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 *R. S. McCann*

Licensed Embalmer No. *2727*

P. O. Address *Springfield*

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.