

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037870

STATE FILE NUMBER

FILED OCT 17 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 8171

300
1-57

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION New Faith Hospital		Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2203 Benton Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lonnie Middle Thomas Last Hollabaugh				4. DATE OF DEATH Month August Day 22 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5, 1909	
9. AGE (In years last birthday) 48		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Clerk		10b. KIND OF BUSINESS OR INDUSTRY Schoenberg Grocer Co		11. BIRTHPLACE (City and state or country) Dover, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Dr. L. S. Hollabaugh			13b. MOTHER'S MAIDEN NAME unknown			14. NAME OF HUSBAND OR WIFE Lucille L. Hollabaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 430-01-1881		17. INFORMANT Address Lucille Hollabaugh, 2203 Benton Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple metastatic generalized carcinoma of the abdomen.						INTERVAL BETWEEN ONSET AND DEATH Since 3/12/58	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) None DUE TO (c) None						1992	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None.				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <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		COUNTY STATE	
21. I attended the deceased from 4/14/58 to 8/21/58 and last saw ^{her} him alive on 8/21/58 Death occurred at Faith Hospital-Midnight on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Joseph A. Costello, M.D.				22b. ADDRESS 2407 a North Broadway		22c. DATE SIGNED 8/22/58	
23a. BURIAL, CREATION, REMOVAL (Specify) Removal VIA RAIL		23b. DATE Aug. 23, 1958		23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cemetery		23d. LOCATION (City, town, or county) (State) Hector, Arkansas	
24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair				25. DATE RECD. BY LOCAL REG. AUG 22 58		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

3.0

OCT 17 1958

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 *Clement McQuay*

Licensed Embalmer No. 3732

P. O. Address *St. Louis*

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.