

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022204

STATE FILE NUMBER

FILED JUN 19 1959

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 48

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Charleston</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Charleston 0672c</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>510 E. Cypress</u>		Length of stay in lb <u>64</u> Years	d. STREET ADDRESS (If outside, give location) <u>510 E. Cypress</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie Swank Holloway</u>			4. DATE OF DEATH Month Day Year <u>5/26/59</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/1871</u>
9. AGE (In years at last birthday) <u>87</u>		10. UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Charleston, Mo. 6</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William P. Swank</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret H. Lee</u>		14. NAME OF HUSBAND OR WIFE <u>Deed</u> <u>George William Holloway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Howard Rice, Scottsburg, Ind.</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>Coronary heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) <u>arterio sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>decompensated</u> <u>Aug 10 58</u> <u>gradual</u>
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 Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Aug 10 1958</u> to <u>May 26 1959</u> and last saw her alive on <u>May 26 1959</u> Death occurred at <u>2:45 A</u> m on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. Charles Salwing M.D.</u>		22b. ADDRESS <u>Charleston, Mo</u>	
22c. DATE SIGNED <u>5/28/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>5/28/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>The Nunnelee Funeral Chapel</u> <u>Charleston, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>6-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Lorady B. Hathorn</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JUL 23 1959

STATEMENT BY LICENSED EMBALMER

BOARD FILE NO. 6-17-59

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 *John F. Munnick Jr*

Licensed Embalmer No. 3851

P. O. Address Charleston, W. Va.

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.