

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029950

FILED VS. SEP 14 1959

Registration District No. 273

Primary Registration District No. 3051

Registrar's No. 97

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY PERRY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST LOUIS															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN PERRYVILLE		Length of stay in 1b 2 1/2 HRS		c. CITY OR TOWN ST LOUIS (7) MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION PERRY CO MEM. HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4324 PRAIRIE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EUGENE HOLLARS				4. DATE OF DEATH Month Day Year 8 5 59															
5. SEX M		6. COLOR OR RACE W		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/5/59		9. AGE (last birthday) IF UNDER 1 YEAR Months Days 2 30		IF UNDER 24 HR Hours Min. 2 30									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY											
13a. FATHER'S NAME CHARLES EUGENE HOLLARS				13b. MOTHER'S MAIDEN NAME KATHLEEN ANN GRASS				14. NAME OF HUSBAND OR WIFE											
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.		17. INFORMANT Charles E. Hollars Address 4324 Prairie St. Louis (7) Mo													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURE DETONATION DUE TO (b) ABRUPTIO PLACENTA DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 2 hrs 12 hrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
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 a.m. p.m. Month, Day, Year		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 8-5-59 , to 8-5-59 and last saw ^{her} him alive on 8-5-59 Death occurred at 1:50 m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) Dr. Genevieve						22b. ADDRESS St. Genevieve, Mo				22c. DATE SIGNED 8-17-59									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/5/59		23c. NAME OF CEMETERY OR CREMATORY VALLE SPRING				23d. LOCATION (City, town, or county) STE GENEVIEVE MO											
24. FUNERAL DIRECTOR Res. Beulah St. Genevieve Mo				ADDRESS		25. DATE RECD. BY LOCAL REG. 8-18-59		26. REGISTRAR'S SIGNATURE Joe J. Zollner											

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ^{not} _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lea Barber

Licensed Embalmer No. 1985

P. O. Address 110. Havana

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.