

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032906

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4473

STATE FILE NUMBER

AMENDED

FILED SEP 25 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>10</u> Yrs	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3231 Prospect Hazelwood Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3235 Forest</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Dell</u> Last <u>Holloway</u>			4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1961</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>5-28-1875</u>	9. AGE (last birthday) <u>86</u> Yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	--------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Windsor, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>Henry Lovelace</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Beaman</u>	14. NAME OF HUSBAND OR WIFE <u>Frank William Holloway</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>None</u>	17. INFORMANT <u>Lorraine Pilgreen</u> Address <u>508 W. 9th Street</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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	---

19. WAS AUTOPSY PERFORMED? YES <input 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.	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 1951 to Sept 8, 1961 and last saw her alive on Sept 7, 1961
Death occurred at 4:15 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jack W. Wolf M.D.</u>	22b. ADDRESS <u>KOP E. 63 St Kansas City, Mo.</u>	22c. DATE SIGNED <u>9/8/61</u>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sedalia, Missouri</u>	23d. LOCATION (City, town, or county) (State)
---	----------------------------	--	---

24. FUNERAL DIRECTOR <u>Stine & McClure Kansas City, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>9-8-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
--	---	---

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
JACK W. WOLF
ITEM NO. SHOULD READ

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 Thomas A. Koehler

Licensed Embalmer No. 4995

P. O. Address K.C., 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.