

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3849-62-016895
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**
FILED APR 25 1962

Registrar's No. **1**

VS 300
Rev. 4/59

1
2 **206**
3
4 **2**
5 **0**
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7 **1**
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12 **61-0**
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Length of stay in 1b	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 FIRMIN DESLOGE		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5961 MINERVA		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM MCKINLEY HOLLOWELL			4. DATE OF DEATH Month Day Year APRIL 9 1962			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 9 1896 65	9. AGE (last birthday) 65	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) KENTUCKY	12. CITIZEN OF WHAT COUNTRY USA.	
13a. FATHER'S NAME TOM HOLLOWELL		13b. MOTHER'S MAIDEN NAME MINNIE SMITH		14. NAME OF HUSBAND OR WIFE NONE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I			16. SOCIAL SECURITY NO.	17. INFORMANT. Address MARY JONES 5961 MINERVA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Terminal pneumonia					2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Repeated					4 days	
DUE TO (c) Cerebrovascular thrombosis					3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332x				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.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
21. I attended the deceased from 1958 to 4-8-62 and last saw her alive on 4-8-62 Death occurred at 4-9-62 11:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) D. Kimball M.D.			22b. ADDRESS 1005 Big Bear		22c. DATE SIGNED 4-13-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4-12-62	23c. NAME OF CEMETERY OR CREMATORY SH. App. to Kentucky	23d. LOCATION (City, town, or county) (State) Princeton, Kentucky			
24. FUNERAL DIRECTOR RELIABLE FUNERAL	ADDRESS 545 13894	25. DATE RECD. BY LOCAL REG. APR 12 1962	REGISTRAR'S SIGNATURE Road Smith, M.D.			

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 Sharence Cross

Licensed Embalmer No. 4755

P. O. Address 1389 UNION

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.