S. No. 2
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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 15 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22952

State File No. 1481

Registration District No. 367

Primary Registration District No. 6076

Registrar's No. 1399

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town PINE LAWN (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: SHAMROCK REST HOME 4 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ______ (Specify whether In this community ______ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County St Louis 96
(c) City or town PINE LAWN 0 (If outside city or town limits, write "RURAL")
(d) Street No. 3709 MANOLA AVENUE 0 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ______

3. (a) PRINT FULL NAME HENRY HOLBORN
3. (b) If veteran, name war ______
3. (c) Social Security No. ______

4. Sex MALE 0
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife HATTIE WATHON
6. (c) Age of husband or wife if alive ______ years
7. Birth date of deceased NOV. (Month) 29 (Day) 1859 (Year)

8. AGE:

Years	Months	Days	If less than one day
87	7	9	______ hr. ______ min.

9. Birthplace ENGLAND 4 (City, town, or county) (State or foreign country)
10. Usual occupation RETIRED PHOTOGRAPHER
11. Industry or business ______

FATHER
12. Name HENRY HOLBORN
13. Birthplace ENGLAND 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace ENGLAND 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jas G Carlin
(b) Address 1016 Tupelo Bl W G
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 (Month) 10 (Day) 47 (Year)
(c) Place: burial or cremation CALVARY CEM.
18. (a) Signature of funeral director T M Mullen
(b) Address 5765 DELMAR BL.
19. (a) 7-10-47 (Date received local registrar) (b) [signature] MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th year 1947 hour 4 minute 45 AM.

21. I hereby certify that I attended the deceased from May 29, 1947, to July 8, 1947, that I last saw him alive on July 5, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	1 week
Due to Arteriosclerotic and hypertensive cardiovascular dis	5 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death) Old cerebral hemorrhage. Bronchiectasis.	
Major findings: Of operations ______ Of autopsy ______	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ______
(b) Date of occurrence ______
(c) Where did injury occur? ______ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ______ (Specify type of place)
While at work? ______ (e) Means of injury ______

23. Signature Lewis Lillyann (M. D. or other) MD
Address 8231 Clayton Rd Date signed 7/8/47

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed J. G. Faust

Licensed Embalmer No. 3384

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 this body is not embalmed, fact should be so stated above.