REC'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003

13506
Do not use this space.

1. PLACE OF DEATH
(a) County
(b) Township
(c) or City St. Louis
Registration District No.
Primary Registration District No.
Registered No. 3848
(d) Street No. City Hospital No.1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

E 966

2. PRINT FULL NAME 400 Thomas Holway
(a) Residence, No. 1510 MARKET Palace Hotel St. 25
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Loretta Holway
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28, 1897
7. AGE YEARS 41 MONTHS 8 DAYS 26 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. clerk
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER
13. NAME James Holway
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

MOTHER
15. MAIDEN NAME Anna Stacia Farrell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Orleans La.

17. INFORMANT (ADDRESS) Hosp. Info M.Kent
18. BURIAL, CREMATION, OR REMOVAL PLACE VALHALLA CEM. DATE APRIL 26, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. Schnur, 3125 Lafayette av.
20. FILED APR 25 1939 J. F. Budeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/24/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 4/21/39, 19, to 4/24/39, 19
I last saw him alive on 4/24/39, 19 Death is said to have occurred on the date stated above, at 7.45 a
The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis, Pneumococcic Type III	4/20/39

496

Other contributory causes of importance: Otitis media, Chronic bilateral Mastoiditis - Ch. bilateral

Name of operation Radical mastoidectomy Date of 4/22/39
What test confirmed diagnosis? L. P. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Thos. D. Haughton, M. D.
(Address) 1515 Lafayette

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

80M-9-1938 I X16605

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 Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette ave

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, above space should be left blank.