

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 24 1949

State File No. 7426

BIRTH NO.		REG. DIST. NO. 37	PRIMARY REG. DIST. NO. 4049	Registrar's No. 14
1. PLACE OF DEATH a. COUNTY <i>Boone County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Boone Mo</i>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Centralia Mo</i>		c. LENGTH OF STAY (in this place) OR TOWN <i>R.F.D.</i>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Hulen's Nursing Home</i>		d. STREET ADDRESS (If rural, give location) <i>0</i>		
3. NAME OF DECEASED (Type or Print) a. (First) <i>Robt. E. M.</i> b. (Middle) <i>Hollow</i> c. (Last) <i>Hollow</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Nov. 20 '49</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/23/57</i>	9. AGE (In years last birthday) <i>91</i> IF UNDER 1 YEAR Months <i>7</i> Days <i>0</i> IF UNDER 6 HRS. Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Calloway Co. Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Robt. Hollow</i>		13b. MOTHER'S MAIDEN NAME <i>Marion Dolow</i>	14. NAME OF HUSBAND OR WIFE <i>Lula Roberts</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Hulen's Nursing Home</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chr. Myocarditis - Secondary</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <i>42'</i>		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>NO</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Centralia Boone Mo</i>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Sept. 20, 1948</i> , to <i>Nov. 20, 1949</i> , that I last saw the deceased alive on <i>Nov. 20, 1949</i> , and that death occurred at <i>6:10 P.M.</i> , from the causes and on the date stated above.				
23a. SIGNATURE <i>J. Williams M.D.</i> (Degree or title)		23b. ADDRESS <i>Centralia Mo</i>		23c. DATE SIGNED <i>3/20/49</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>Mar. 22, 1949</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Millersburg</i>	24d. LOCATION (City, town, or county) (State) <i>Calloway - Co. Mo</i>	
DATE REC'D BY LOCAL REG. <i>March 20, 1949</i>	REGISTRAR'S SIGNATURE <i>Maud Mc Bride</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Wallace Funeral Home</i>	ADDRESS <i>7 W. 6. St. Fulton Mo.</i>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

RECEIVED  
District Health Officer No. 9,  
District File Number 3-22-49  
Date Filed \_\_\_\_\_

**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.

Signed Wm. E. Browning

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2724

P. O. Address Hullon Ind

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.