MICHIGAN DEPARTMENT OF HEALTH
Division of Vital Statistics
TRANSCRIPT OF CERTIFICATE OF DEATH—LOCAL REGISTER

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form 93a—9-5-21—1000 Books—100 pages.

1 PLACE OF DEATH

County _Vernonttl_

Township _11_

Village _1'_

City _____

Registered No. _5_

(No. _____ St. _____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME _Charles Christopher Hollenbeck_

(a) Residence No. _____ St., Ward _____ (If non-resident give city or town and state)
(Usual place of abode)
Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	**4 Color or Race**	**5 Single, Married, Widowed or Divorced** (*Write* the word)
Male	_White_	_marj'd_

5a If married, widowed or divorced HUSBAND of (or) WIFE of _Alice Hollenbeck_

6 DATE OF BIRTH (Month, day and year) _Nov. Feb 18 1858_

7 AGE	Years	Months	Days	If LESS than
	66	7	17	1 day ___ hrs. OR ___ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _Banke_
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer.

9 BIRTHPLACE (city or town) _Mich._
(state or country)

PARENTS

10 NAME OF FATHER _C. J. Hollenbeck_

11 BIRTHPLACE OF FATHER (city or town) _N. York Sta_
(state or country)

12 MAIDEN NAME OF MOTHER _Elizebeth Homer_

13 BIRTHPLACE OF MOTHER (city or town) _N York Stt_
(state or country)

14 Informant _Alice J. Hollenbeck_
(Address) _Vernontll_

15 Filed _7/18_, 19_23_ _C. ___ _____ Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) _7 / 15_ 19_25_

17 I HEREBY CERTIFY, That I attended deceased from _____, 19_A_, to _____, 19_____
that I last saw h__ alive on _7 / 5_, 19_25_ and that death occurred on the date stated above at _10.0_ m.
Feb 18 1858
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY _____
(Secondary)
(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? ___ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _C. S. Snell_, M. D.
___, 19 , Address

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	Date of Burial
	19
2 UNDERTAKER	Address

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