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.

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

PLACE OF DEATH

County Jasper

Township or Village or City Carthage (NO. Garrison St.; Ward)

Registration District No. 408 File No. 1573

Primary Registration District No. 3020 Registered No. 5

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James R Holbrook

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Nov 14, 1849 (Month) (Day) (Year)

AGE: 63 yrs. 2 mos. ___ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): 1245 924 99

BIRTHPLACE (City or town, State or foreign country): Madison Co., N.Y.

PARENTS
NAME OF FATHER: Thomas Holbrook
BIRTHPLACE OF FATHER (City or town, State or foreign country): New York
MAIDEN NAME OF MOTHER: Mary Coates
BIRTHPLACE OF MOTHER (City or town, State or foreign country): New York

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. G. Holbrook

(ADDRESS) Carthage, Mo

Filed Jan 16, 1913. James B Lund REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. 14, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug, 1912, to Jan 14, 1913, that I last saw him alive on Jan 14, 1913, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis & Cirrhosis of Liver, Valvular heart lesion

(Duration) Dont Know yrs. mos. ds.

Contributory (SECONDARY) Acute dilatation Cft. ventricle (Duration) yrs. mos. 1 ds.

(Signed) W H Gentry M. D.

Jan 15, 1913 (Address) Carthage Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence: Carthage, Mo.

PLACE OF BURIAL OR REMOVAL: Park Cemetery

DATE OF BURIAL: Jan 16, 1913

UNDERTAKER: Knell Und Co.

ADDRESS: Carthage, Mo.

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.

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.:.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS