WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANEN.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should 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 Tony

Township Big Creek

or

Village

or

City (NO. , St.; Ward)

Registration District No. 858

Primary Registration District No. 2126

File No. 43631a

Registered No.

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

FULL NAME George A Holt

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	Married

DATE OF BIRTH December (Month) 21 (Day), 1845 (Year)

AGE 70 yrs. 11 mos. 8 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) ~~[illegible]~~ MO

PARENTS
NAME OF FATHER Fielding Holt
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.
MAIDEN NAME OF MOTHER Dont Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adeline Holt

(ADDRESS) Protem MO

Filed DEC 10 1916 J O Nicholson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 29 (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 25, 1916, to Nov 28, 1917, that I last saw him alive on Nov 28, 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Dont Know. He had been suffering from General Senility for year or two. Died Suddenly

1/4 (Duration) 188 yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) J O Nicholson M. D.

4/26, 1917 (Address) Protem 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

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Protem Mo	Nov 29, 1917
UNDERTAKER	ADDRESS
J. F. Keesie	Protem Mo.

PLACE OF DEATH

County _____

Township _____ or

Village _____ or

City _____ (NO. _____, _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALT

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred hospital or institut give its NAME ins 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 fr _____, 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

_____ mos. _____ ds.

_____ M. D.

_____

Violent Causes, stat icidal or Homicidal. utions, Transients.

_____ mos. _____ ds

_____

OF BURIAL

_____, 191____

ESS

UNFADING INK—THIS IS A PERMANENT RECORD

refully supplied. AGE should be stated EXACTLY. PHYSICIANS should state t may be properly classified. Exact statement of OCCUPATION is very important.