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

Do not use this space.

21485

1. PLACE OF DEATH

County: Jackson Kan. Registration District No.: 399

Township: Kansas City Primary Registration District No.: 1097 File No.: [illegible]

City: Missouri (No.: Old City Hospital St. Ward) Registered No.: [illegible]

2. FULL NAME Logan Holley

(a) Residence. No. St. Ward. St Jo Mo
(Usual place of abode) (If nonresident give city or town and State)

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.

St Joseph Mo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR ~~OR RACE~~: wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
58				

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Owen Holley

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo

12. MAIDEN NAME OF MOTHER: Mary Holley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo

14. INFORMANT: Mrs Mary Jones
(Address): 1821 Dalton st St Jos

15. FILED 7/18, 1927 M. M. Crouse Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-15 1927

17. I HEREBY CERTIFY, That I attended deceased from 6-1, 1927, to 7-15, 1927, that I last saw b~~orn~~ alive on 7-15-27, and that death occurred, on the date stated above, at 9:35 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Adhesive Pericarditis
96
9 d 3
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): General Paresis of Insane
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

O DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings

(Signed) Lab. H. M. Smith M. D.

7/16, 1927 (Address) Old City Hospital

*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: Blue Ridge Cemetery — DATE OF BURIAL: 7-18 1927

20. UNDERTAKER: S H B Moore — ADDRESS: 1820 E 18

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.