

MAR 21 1928 *Clats*

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

Do not use this space.

5874

1. PLACE OF DEATH

County *Pettis*  
Township  
City *Sedalia* (No. *1*)

Registration District No. *668*  
Primary Registration District No. *3032*

File No.  
Registered No. *64*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Mary Elizabeth Holt*

(a) Residence. No. *312 No. Grand St.* Ward. *4*  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 5 - 1848*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *79 9 22*

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

9. BIRTHPLACE (CITY OR TOWN) *Marion Co Mo* (STATE OR COUNTRY)

10. NAME OF FATHER *Edward Nett*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Ohio* (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *M. Rollins*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Ohio* (STATE OR COUNTRY)

14. INFORMANT *William Holt* (Address) *Sedalia Mo*

15. FILED *2-29-28* 19 *28* *J.S. Love* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2/27* 19*28*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 20* 19*28*, to *Feb 26* 19*28* that I last saw her alive on *Feb 27* 19*28*, and that death occurred, on the date stated above, at *12:20 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Influenza*  
*162* (duration) yrs. mos. da.

CONTRIBUTORY SECONDARY *Age - Mitral Regurgitation* (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH. DATE OF \_\_\_\_\_ WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *E. F. Stearns*, M. D. *2-29*, 19*28* (Address) *Sedalia Mo*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Sedalia Mo* DATE OF BURIAL *Feb 29* 19*28*

20. UNDERTAKER *McHughlin Bros* ADDRESS *Sedalia*

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.

