

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

Do not use this space.

8908

1. PLACE OF DEATH

County Jackson
Towship Raw
City H.C.Mo.

Registration District No.
Primary Registration District No.
(No. 3439 Charlotte St)

File No.
Registered No. 1079
St. Ward)

2. FULL NAME

Isaac H. Holmes

(a) Residence. No. 3439 Charlotte St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

male | White | Widowed

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

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

Sept 24 1856

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>72</u>	<u>6</u>	<u>unb</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter
(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) Illinois

10. NAME OF FATHER

Harris Holmes

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) No Record

12. MAIDEN NAME OF MOTHER

No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) No Record

14.

INFORMANT Clayton P. Holmes
(Address) 3439 Charlotte

15.

FILED 3-10-28 M. M. Crowe
REGISTRAR Asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Feb-9-28

17.

I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at 4:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Left Hemiplegia
9:55
10 (duration)..... yrs..... mos..... da.

CONTRIBUTORY (SECONDARY)

Chronic Myocarditis
(duration)..... yrs..... mos..... da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? History

(Signed) H. E. Mass M.D.

3-9-28 (Address) Coroner

*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

Red Cloud, Neb. 3/1/28

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster H.C.Mo.

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.

