

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

Do not use this space.

13715

1. PLACE OF DEATH

County Andrew
Township Benton
City Atter

Registration District No. 9
Primary Registration District No. 50129

File No. 119
Registered No. 119
St. _____ Ward _____

2. FULL NAME

Ora Kathleen Holtclaw

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

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) MC

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4 - 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 8 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Madaway
(STATE OR COUNTRY) Mo

10. NAME OF FATHER James R. Silver

11. BIRTHPLACE OF FATHER (CITY OR TOWN) un known
(STATE OR COUNTRY) Penn

12. MAIDEN NAME OF MOTHER Elija Shepler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) un known
(STATE OR COUNTRY) Penn

14. INFORMANT J. W. Holtclaw
(Address) Roa. Mo

15. FILED Apr 5 1929 J. W. Lamm REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-4-1929

17. I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 3, 1929, that I last saw h. alive on April 3, 1929, and that death occurred, on the date stated above, at 1:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis, muralis
capit edemii of electro

CONTRIBUTORY (SECONDARY) myocarditis
(duration) 1 yrs. 1 mos. 1 da.

18. WHERE WAS DISEASE CONTRACTED home
IF NOT AT PLACE OF BIRTH.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? inspection
(Signed) D. R. Wilson, M. D.

(Address) Reardan Mo

*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 Belkrow DATE OF BURIAL 4-5-1929

20. UNDERTAKER C. C. Brit ADDRESS Savannah Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

APR 23 1929

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10/18/88

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10/18/88