

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

Do not use this space.

18296
2341

1. PLACE OF DEATH

County Jackson Registration District No. 300
Township Kaw Primary Registration District No. 1002
City Kansas City (No. Kansas City Genl Hosp St. _____ Ward)

2. FULL NAME

Charles Hollinberg
(a) Residence. No. 2620 E 9th St. 9 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 5, 1868</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>61</u>	<u>1</u>	<u>15</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work. <u>Auto painter</u>				
(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) Pa

PARENTS

10. NAME OF FATHER Geo. Hollinberg

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

12. MAIDEN NAME OF MOTHER unknown

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

14.

INFORMANT De cord Clerk
(Address) K.C. General Hosp

15.

FILED 5/21, 1929 M.M. Crowe
asst. REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-20 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-1, 1929 to 5-20, 1929 that I last saw him alive on 5-20, 1929 and that death occurred, on the date stated above, at 5:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Syphilis of aorta with
Aneurysm
34
96

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P. Williams, M. D.
5-20, 1929 (Address) Supt K.C. Genl Hosp

*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

Mt. Hope Cemetery

DATE OF BURIAL

5-22 29

20. UNDERTAKER

H.W. Gates

ADDRESS

K.C.K.

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.

85-
2
2
2

