

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

Do not use this space.
27722
3411

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 4023 Tracy 002
City Kansas City (No. 4023 Tracy 002) St. _____ Ward _____

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

2. FULL NAME Charles F. Hollister

(a) Residence No. 4023 Tracy St. 15 Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 24, 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	52	5	14	

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

9. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER ***Hollister

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Don't know

14. INFORMANT Mr. Mary L. Hollister
(Address) 4023 Tracy

15. FILED 8/9 1929 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 8 19 29

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929 to Aug 8, 1929
that I last saw him alive on Aug 8, 1929, and that death occurred, on the date stated above, at 3:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
72 C
115 A
(duration) 3 yrs. mos. ds.
CONTRIBUTORY infected with 7 Louis
(SECONDARY) (duration) 15 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no (STATE OF _____)
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination
(Signed) Milton B. Caselalt, M. D.
8/9 1929 (Address) 1207 Kialto Bldg. K. C. 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 Cremation, Elmwood Cemetery DATE OF BURIAL 8-10-1929

20. UNDERTAKER R. V. LINDSEY & SONS, Inc ADDRESS K. C. Mo

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.

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