

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

Do not use this space.

36519

1. PLACE OF DEATH
 County Callaway Registration District No. 104
 Township Fulton Primary Registration District No. 5153
 City..... (No..... St..... Ward)

File No.....
 Registered No. 238

2. FULL NAME William Henry Holman
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) II/2 1834

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	95	0	18	

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)
 (c) Name of employer

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

10. NAME OF FATHER Henry Holman

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

12. MAIDEN NAME OF MOTHER Elizebeth Jones

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

14. INFORMANT Judge Ed. Holman
 (Address) R?F.D. Fulton Mo.

15. Nov 21 19 29 R. N. Crews
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) II/20 19 29

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 25 to Nov 20 19 29
 that I last saw him alive on Nov 20 19 29 and that death occurred, on the date stated above, at 6 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertrophy of prostate gland
137
132B (duration) chronic yrs. mos. da.

CONTRIBUTORY (SECONDARY) Uremic poisoning (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) R. N. Crews M. D.
 19 (Address) Fulton 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 Hamsprarie Cemetry DATE OF BURIAL I 1/22 29

20. UNDERTAKER Herndon Taylor ADDRESS Fulton 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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