

SEP 22 1930

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

Do not use this space.

26056

1. PLACE OF DEATH

County Callaway  
Township.....  
City Fulton (No. ....)

Registration District No. 104  
Primary Registration District No. 3008

File No. ....  
Registered No. 192  
St. .... Ward)

2. FULL NAME Allyne Joan Holmes

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/22 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
2 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None  
(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) Mo.

10. NAME OF FATHER Jimmie Holmes

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

12. MAIDEN NAME OF MOTHER Minnie Gifford

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

14. Jimmie Holmes  
INFORMANT.....  
(Address) Fulton Mo.

Aug 23 1930 R. W. Crews  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/22 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1930, to Aug 22, 1930, that I last saw her alive on Aug 22, 1930, and that death occurred, on the date stated above, at 8.30 A.M. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Gastro-entero-colic  
12015  
103  
(duration) yrs. mos. ds.

CONTRIBUTORY Rickets  
(SECONDARY)  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

114B  
IF NOT AT PLACE OF DEATH.....  
DID IN OPERATION PRECEDE DEATH? No DATE OF.....  
WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) R. W. Crews, M. D.  
, 19 (Address)

\*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 Hillcrest Cemetery DATE OF BURIAL 8/23 1930

20. UNDERTAKER Herndon Taylor ADDRESS Fulton 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.

