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

Do not use this space.

30157

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 3965
Township Kaw — Primary Registration District No. 1002 — Registered No.
City Kansas City (No. Genl Hospital #2 St. Ward)

2. FULL NAME Harold Holiday
(a) Residence. No. 2425 Paseo St., 4 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: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch 1865

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 65 | ? | ? | |

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) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Unknown

14. INFORMANT Alex Holliday
(Address) 1821 Paseo

15. FILED 9/29 1930 M. M. Crowe REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/26 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-28, 1929, to 9-26, 1930 that I last saw her alive on 9-26-30, 1930 and that death occurred, on the date stated above, at 2:10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
Chronic Nephritis
113 11
92 P
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1290
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) D. M. Miller M.D.
9/27, 1930 (Address) General Hospital #2

*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: Highland Cem.
DATE OF BURIAL: 9/29 1930

20. UNDERTAKER: Watkins Bros Undt Co
ADDRESS: 1729 Lydia

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.