

REC'D SEP 19 1938

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

28139  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002 Registered No. 98  
(c) City Kansas City (d) Street No. St. Joseph Hosp. St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

Infant Holman S.B. 455  
(a) Residence, No. Lexington, Mo. St. Frington Mo  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 8, 1938

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant  
9. Industry or business in which work was done, as saw mill, bank, etc.   
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. C.

FATHER 13. NAME G. E. Holman

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

MOTHER 15. MAIDEN NAME Alda Simonetti

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

17. INFORMANT C. E. Holman  
(ADDRESS) Lexington, Mo.

18. BURIAL, CREMATION, OR REMOVAL Removal  
PLACE Lexington, Mo DATE 8/8/38

19. FUNERAL DIRECTOR (NAME) W. F. Mayberry  
(ADDRESS) 2515 Linwood Blvd. K. C. Mo.

20. FILED Aug 8, 1938 M. M. Browne  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/8/38 19

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 4:30 a.m.

The principal cause of death and related causes of importance were as follows:

Intra-cranial hemorrhage Date of onset

Other contributory causes of importance:

Persistent occipital fontanelle protrusion

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? Yes

If so, specify \_\_\_\_\_

(Signed) W. F. Mayberry M. D.  
(Address) 107 Bryant Bldg, K.C. Mo.

U  
Bergman Bldg  
LL 0848

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**