

DEC'D JUN 8 1939

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

17645  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson / Registration District No. 399  
 (b) Township Kaw / Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. St. Joseph Hospital Registered No. 2047  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 8 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jessie C. Holler.

(a) Residence, No. 1925 Ashland St.  Mr. Washington 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

MEDICAL CERTIFICATE OF DEATH

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 Effie Holler  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9 - 3 - 1903  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
35 8 11  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed  
 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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/14/39  
 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 \_\_\_\_\_ pm.  
 The principal cause of death and related causes of importance were as follows:

Arteriosclerosis  
Anginal injury of the heart  
Exhaustion  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 210 ft

12. BIRTHPLACE (CITY OR TOWN) Bagnell (STATE OR COUNTRY) Missouri 0  
 FATHER 13. NAME William Holler 1  
 14. BIRTHPLACE (CITY OR TOWN) Morgan County (STATE OR COUNTRY) Indiana 0  
 MOTHER 15. MAIDEN NAME Annie Quinn  
 16. BIRTHPLACE (CITY OR TOWN) No Record (STATE OR COUNTRY) Missouri

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy \_\_\_\_\_  
 23. If death was due to external causes (poison, etc.), fill in also the following: Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_  
 Where did injury occur? 1901 Ashland Jackson Mo (Specify city or town, county, and State)

17. INFORMANT Mrs. Lallie Simpson (ADDRESS) 1602 Skiles Ave. K. C. Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Salem Church DATE May 16, 1939

Specify whether injury occurred in \_\_\_\_\_ in home, or in public place.  
 Manner of injury Struck by Motor Car  
 Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (NAME) Henry W. Stahl. (ADDRESS) 815 W. Maple Ave. Independence Mo.  
 20. FILED May 16 1939 M. M. Brown Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) [Signature] \_\_\_\_\_, M. D.  
 (Address) [Signature]

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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**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.**