

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.

JUL 14 1939

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

23389  
Do not use this space.

1. PLACE OF DEATH *Scotland* W  
(a) County *Scotland* Registration District No. *811*  
(b) Township *Sandhill* Primary Registration District No. *6659*  
(c) or City (d) Street No. \_\_\_\_\_ St.  
(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. ds.  
2. PRINT FULL NAME *Charles S. Holman*  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *whit* 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) *Oct 26 1966*  
7. AGE YEARS *72* MONTHS *7* DAYS *23* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *former*  
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) *Scotland Co Mo*  
13. NAME *Timothy Holman*  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Estell Co Kentucky*  
15. MAIDEN NAME *Cole*  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Scotland Co Mo*  
17. INFORMANT *Arthur Holman* (ADDRESS) *Keokuk Iowa*  
18. BURIAL, CREMATION, OR REMOVAL PLACE *Berthel* DATE *6/24/39*  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Baird & Co* *Hubbidge Mo*  
20. FILED *June 20, 1939* *May S. Hume* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6/18/39*  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_  
I last saw him *in death* to *June 20, 1939* Death is said to have occurred on the date stated above, at *8 P.M.*  
The principal cause of death and related causes of importance were as follows:  
*General senility following influenza about 1 yr ago*  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: *118*  
Name of operation *no* Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *no*  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? *no* 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?  
If so, specify \_\_\_\_\_  
(Signed) *E. E. Symmonds* \_\_\_\_\_  
(Address) *Memphis, Mo*

RECEIVED

District Health Officer No. 10

District File Number 7-39-1226

Date Filed JUL 12 1939

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. 3175  
working under my personal supervision.

Signed

*James A. Bailey*

Licensed Embalmer's No.

3175

P. O. Address

*Rutledge, Mo*

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.