

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo**
(c) Name of hospital or institution: **727 Harrison**
(d) Length of stay: In hospital or institution **no**
In this community **Unknown**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo**
(d) Street No. **727 Harrison**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Thomas Holmstrom

3. (b) If veteran, name was **Spanish-American** 3. (c) Social Security no. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **deceased** (c) Age of husband or wife if alive **deceased** years

7. Birth date of deceased **Feb. 24 - 1867**

8. AGE: Years **78** Months **7** Days **24** If less than one day **✓** hr. **✓** min.

9. Birthplace **Telemore, Ireland**

10. Usual occupation **Laborer**

MOTHER FATHER
11. Industry or business _____
12. Name **Unknown**
13. Birthplace **Unknown**
14. Maiden name **Unknown**
15. Birthplace **Unknown**

16. (a) Informant's own signature **John F. Guinan**

(b) Address **1112 East 13, Stanton**

17. (a) **Burial** (b) Date thereof **Oct-21-39**

(c) Place: burial or cremation **St. Mary Cem**

18. (a) Signature of funeral director **A. P. Doster**
(b) Address **1415 E 15, St. Joe Mo**
19. (a) **10/20/39** (b) **M. M. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **18** year **1939** hour **6** minute **15 P** M.

21. I hereby certify that I attended the deceased from **Nov. 19 1938** to **Oct 18 1939**; that I last saw him alive on **Oct 16 1939**; and that death occurred on the date and hour stated above.

Immediate cause of death **Alcoholism**

Due to _____

Due to **175/10**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature **E. M. Connelley** (M. D. or other) _____

Address **Kan City, Mo** Date signed **10/19/39**

Duration

yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

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.

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.....

H. P. Doehler, Registered Apprentice No.
working under my personal supervision.

Signed

H. P. Doehler

Licensed Embalmer No. 1166

P. O. Address 1415 East 15

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.