

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

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35199

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4174

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 days  
(Specify whether years, months or days)  
In this community 11 days

REC'D NOV 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County PLATTE  
(c) City or town PLATTE CITY - MO.  
(If outside city or town limits, write "RURAL")  
(d) Street No. RURAL.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? ✓ years.

3. (a) PRINT FULL NAME GEORGE - THOMAS - HOLYBEE

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MARY 6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased JULY - 29 1861  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 1 day If less than one day hr. ✓ min. ✓

9. Birthplace MO  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business RETIRED

12. Name SAMUAL - HOLYBEE  
13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

14. Maiden name SARAH EARLY  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature  
(b) Address 2117 East 37 ST

17. (a) BURIAL (b) Date thereof 11 - 1 - 39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation PLATTE - CITY MO

18. (a) Signature of funeral director Howard J. Roe  
(b) Address 3146 Main

19. (a) 10/31/39 (b) M. M. Grome  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 30  
year 1939 hour 11:30 minute P. M.

21. I hereby certify that I attended the deceased from 6-1-39  
to 10-30-39, 1939, to 10-30-39, 1939  
that I last saw him alive on 10-30-39, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 10 min.

Due to 121

Due to

Other conditions Recent Appendicitis  
(Include no. in parentheses within 3 months of death) 10-22-39

Major findings: Stomach & Spleen PHYSICIAN

Of operations

Of autopsy

Underline the cause to which death should be charged statistically

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 Frank E. Verhorne (M. D.)  
Address Platte City, MO Date signed 10-30-39

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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 Howard J. Roe

Licensed Embalmer No. 2748

P. O. Address K C 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.**