

Registration District No. **399**
FILED MAR 11 1940

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **23 days**
(Specify whether years, months or days) **9 Yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3514 Fuller Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **FRANCES LUCILLE HOLT**
(b) If veteran, name war No. _____ (c) Social Security No. **NO.**

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Wm. E. Holt** 6. (c) Age of husband or wife if alive **48** years
7. Birth date of deceased **May 7th, 1893**
(Month) (Day) (Year)

8. AGE: Years **46** Months **9** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **Atlanta Ga.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Evans**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **..**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **William L. Holt**
(b) Address **3514 Fuller Ave.**

17. (a) **Burial** (b) Date thereof **2/22/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Brooking Cemetery**

18. (a) Signature of funeral director **H. F. Mayberry**
(b) Address **2315 Linwood Blvd.**

19. (a) **2-22-40** (b) **M. M. Craue**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **20th**
year **1940** hour **9:00 A.M.** Minute _____ M.

21. I hereby certify that I attended the deceased from **1-28-40**, 19____, to **2-20-40**, 19____;
that I last saw h. **or** alive on **2-20-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of left tibia due to accidental fall**

Due to _____
Due to _____

Other conditions **Brown atrophy of heart; Cardiac decampensation; fatty degeneration of liver**
(Include pregnancy within 3 months of death)
Of operations _____

Of autopsy **See above**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Acc.**
(b) Date of occurrence **1-28-40**
(c) Where did injury occur? **at home**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
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While at work? _____ (Specify type of place)
(e) Means of injury **Fall**

23. Signature **Dr. De Maria** (M. D. or other) _____
Supt. K.C. Gen. Hospital K.C. Mo. Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.

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..... *Roy C. Snow*

Licensed Embalmer No..... **2560**

P. O. Address **2315 Linwood Blvd.**

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.