

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24206

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2816

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

1. PLACE OF DEATH: Jackson
(a) County: Jackson
(b) City or town: Kansas City
(c) Name of hospital or institution: 924 Olive
(d) Length of stay: In hospital or institution: 20 Yrs.
In this community: 20 Yrs.

3. (a) PRINT FULL NAME: Fred Holmes 452
(b) If veteran, name war: None
(c) Social Security No.: NONE

4. Sex: M 5. Color or race: Col
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Callie Holmes
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: April 24 1878

8. AGE: Years 62 Months 2 Days 13
If less than one day hr. min.

9. Birthplace: Jackson Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business: /

MOTHER FATHER { 12. Name: Henry Holmes
13. Birthplace: Miss.
14. Maiden name: Lizzie
15. Birthplace: Mississippi

16. (a) Informant: Mrs. Callie Holmes
(b) Address: 924 Olive

17. (a) removal (b) Date thereof: 7-13-40
(c) Place: burial or cremation: Lincoln Cem
H Atkins Bros

18. (a) Signature of funeral director: Lydia
(b) Address: 1729 Lydia

19. (a) July 13, 1940 (b) M. M. Crow

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(d) Street No.: 924 Olive
(e) If foreign born, how long in U. S. A.?

20. DATE OF DEATH: Month: 7 Day: 7 Year: 1940
hour: minute: 30 M.

21. I hereby certify that I attended the deceased from 19... to 19...
that I last saw the deceased on 19...
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Pulmonary Edema
Due to: Cardio-Respiratory Distress
Due to: Sclerosis of Arteries
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?
(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: _____ (M. D. or other)
Address: _____ Date signed: _____

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

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.....

Jerome Manlove
.....
Licensed Embalmer No. *3994*

P. O. Address *11 St. E. 23rd*

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, fact should be so stated above.