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13-40
7-39
X23159

Registration District No. 721

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(c) Name of hospital or institution: St. John's Hospital
(d) Length of stay: In hospital or institution
In this community years, months or days

3. (a) PRINT FULL NAME Delbert W. Holt
3. (b) If veteran, name war No. 3. (c) Social Security No. 492-05-1912

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clara 6. (c) Age of husband or wife if alive 27 years
7. Birth date of deceased June 22 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 3 17 hr. min.

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

10. Usual occupation Brakeman
11. Industry or business M-K-T E.R.

12. Name Francis Holt
13. Birthplace Unknown
14. Maiden name Mary Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Holt
(b) Address Booneville, Mo.

17. (a) Removal (b) Date thereof 10-11-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Booneville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) OCT 11 1940
(Date received local Registrar's) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cooper
(c) City or town Booneville NR
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1940 hour 11:15 minute A.M.

21. I hereby certify that I attended the deceased from Sept. 29, 1940, to October 9, 1940
that I last saw him alive on Oct. 9, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Tumor of Brain
Type unknown as to malignancy
Due to 55d
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Tumor of Brain
Of operations
Of autopsy Yes - Findings incomplete.

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?

23. Signature A. M. Deane (M. D. or other)
Address 4912 Maryland Date signed 10/10/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.