

No. 2
17
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JAN 21 1941
Registration District No. 574

Primary Registration District No. 5773

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

1. PLACE OF DEATH:

(a) County Moniteau

(b) City or town Warrior Iron Ship Co.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days 2

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Moniteau

(c) City or town Near High Point
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Kernith Leroy Holder

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28 year 1940 hour 8 minute P M.

21. I hereby certify that I attended the deceased from Dec. 24, 1940, to Dec. 28, 1940 and that death occurred on the date and hour stated above.

that I last saw him alive on Dec. 27, 1940

Immediate cause of death: Broncho-pneumonia 4 days Duration

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

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

7. Birth date of deceased: Oct 29 1940
(Month) (Day) (Year)

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years _____ Months 1 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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

11. Industry or business _____

12. Name Mr. Holder

13. Birthplace Moniteau Co MO
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Hodges

15. Birthplace Coale County MO
(City, town, or county) (State or foreign country)

16. (a) Informant William Holder

(b) Address California MO

17. (a) Burial (b) Date thereof 12/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director William Holder

(b) Address California MO

19. (a) 12/30-1940 (b) Jewel W. Phillips
(Date received local registrar) (Registrar's signature)

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? _____

(e) Means of injury _____

23. Signature W. Banion (M.D. or other) DO

Address California, MO Date signed 12/29/40

1072

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 43254

Registration District No. 576

Primary Registration District No. 5773A

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Moniteau
(b) City or town Harrison T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Kennith Leroy Holder

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 29 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28 year 1970 hour..... minute..... M.

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

Immediate cause of death Broncho pneumonia Duration.....
Due to no complications or previous ailment
Due to.....

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 K. J. Bannon (M. D. or Other).....

Address California Date signed.....

SUPPLEMENTAL

1970

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

S-43254