

REG. JAN 24 1942
Registration District No. 399

Primary Registration District No. 100

Registrar's No.

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

1. PLACE OF DEATH: Jackson
 (a) County: Kansas City
 (b) City or town: Kansas City
 (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: 28 days
 In this community: 8 years 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME: JAMES C. HOLT
 3. (b) If veteran, name war: --
 3. (c) Social Security No.: unk

4. Sex: M. 0
 5. Color or race: White
 6. (a) Single, widowed, married, divorced: Married
 6. (b) Name of husband or wife: Unknown
 6. (c) Age of husband or wife if alive: unk years
 7. Birth date of deceased: March 14th 1877 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	9		hr. min.

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

10. Usual occupation: Barber

11. Industry or business: ...

MOTHER FATHER
 12. Name: Henry Holt
 13. Birthplace: Va. (City, town, or county) (State or foreign country)
 14. Maiden name: Hollie West
 15. Birthplace: Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Record clerk

(b) Address: K.C. Gen. Hospital

17. (a) Burial (b) Date thereof: 12-30-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Burial

18. (a) Signature of funeral director: Wm. A. Johnson

(b) Address: City, Missouri

19. (a) 1/30/1941 (Date received for local registration) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Jackson 048
 (c) City or town: Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 1310 Campbell
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.: 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14th
 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 11-16-41, 19 to 12-14-41, 19; that I last saw him alive on 12-14-41, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Gangrenous Metritis and Pelvic

Due to: Benign Prostatic Hypertrophy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: 137a

Of autopsy: See above

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: Dr. R. Thorne (M. D. or other)

Address: Med. Dir. K.C. Gen. Hospital 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 Wm A. Thompson
Licensed Embalmer No. 3089
P. O. Address 1500 W. 1st St.

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.