

FILED JUL 11 1942  
Registration District No. 4056

Primary Registration District No. 4056

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

1. PLACE OF DEATH:  
(a) County Caldwell  
(b) City or town Breckenridge  
(c) Name of hospital or institution: no  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
In this community 7 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED: 13  
(a) State Missouri (b) County Caldwell  
(c) City or town Breckenridge  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? no years.

3. (a) PRINT FULL NAME CHARLES WILSON HOLMES  
3. (b) If veteran, name war no  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 27  
year 1942 hour 11 am minute 31 A.M.  
21. I hereby certify that I attended the deceased from November 2  
....., 1941 to April 27, 1942.  
that I last saw him alive on April 27, 1942  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
(b) Name of husband or wife Lilly May Holmes  
6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased FEB. 5 1859  
(Month) (Day) (Year)

Immediate cause of death Chronic Nephritis  
Duration April 27

8. AGE: Years 83 Months 2 Days 22  
If less than one day hr. min.

Due to \_\_\_\_\_  
Due to 1318

9. Birthplace Greenwich Conn.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer Ice man & Gardener

Other conditions (include pregnancy within 3 months of death)  
J. D. Underwood D.O.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Charles Holmes  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Lilly Ann Steadman  
15. Birthplace Mass.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Charles Holmes  
(b) Address Breckenridge Mo.  
17. (a) Burial (b) Date thereof Apr. 29 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rose Hill Cemetery  
18. (a) Signature of funeral director F. J. McPuck  
(b) Address Breckenridge Mo.  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature J. D. Underwood (M. D. or other) F. O.  
Address Breckenridge Mo. Date signed Apr 28

1151

CHARLES W. WELLS

**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.....

*T. F. McPuck*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed: *T. F. McPuck*

Licensed Embalmer No. *1570*

P. O. Address *Buckeye Mo.*

**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

State File No. 26779

Registration District No. 94

Primary Registration District No. 4056

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Breckenridge  
(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. 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles W. Holmes

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day \_\_\_\_\_ Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

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

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

7. Birth date of deceased Feb 5 1885  
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) April 29 1942 (b) E. A. Thompson  
(Date received local registrar's certificate) (Registrar's signature)

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

