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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 12 1942  
Registration District No. 186

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24078

State File No. \_\_\_\_\_  
Registrar's No. 14

Primary Registration District No. 6269

2200  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH  
(a) County Christian  
(b) City or town Kettner - Rural  
(c) Name of hospital or institution: Kinder Camp  
(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

3. (a) PRINT FULL NAME ANNA HOLT  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Female / race white  
5. Color or race white  
6. (a) Single, widowed, married, divorced 2  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 21 1942  
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 17  
If less than one day hr. min.

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

10. Usual occupation Housewife work

11. Industry or business \_\_\_\_\_  
12. Name Daniel Gilbert  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown, Turney  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Holt  
(b) Address Kettner Mo

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bruner

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

19. (a) 8-8-1942 (b) Mrs M Johnson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 22  
(a) State MO (b) County CHRISTIAN  
(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.? 0 years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 21  
year 1942 hour 82 minute - A. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to NO physician  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**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

State File No. 24078  
Registrar's No. 14

Registration District No. 185

Primary Registration District No. 5259

1. PLACE OF DEATH:

- (a) County Christian
- (b) City or town Rural  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month July Day 2 Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.
- 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; and that I first saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

- 3. (a) PRINT FULL NAME Anna Holt
- 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

- 6. (b) Name of husband or wife Andy Holt 6. (c) Age of husband or wife if deceased 79-10-34 years

- 7. Birth date of deceased July (Month) 2 (Day) (Year) \_\_\_\_\_

- 8. AGE: Years 64 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 \_\_\_\_\_

- 12. Name \_\_\_\_\_

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

- 14. Maiden name \_\_\_\_\_ (State or foreign country)

- 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) Mrs S. M. Johnson (Registrar's signature) \_\_\_\_\_ (Date received local registrar)

- Due to Had no medical care
- Due to Can't find cause of death
- Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

- Major findings: Of operations \_\_\_\_\_
- Of autopsy 200

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

- 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 Mrs S. M. Johnson \_\_\_\_\_ (Date) \_\_\_\_\_ or other \_\_\_\_\_
- Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

