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23855

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29833

State File No. \_\_\_\_\_

FILED OCT 15 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 1006

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

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7  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town St. Joseph,  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 3 days,  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Andrew,

(c) City or town Amazonia,  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John W. Holcomb,

3. (b) If veteran, name war None,

3. (c) Social Security No. 499-20-1432

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th.  
year 1942 hour 2:00 minute P.M.

4. Sex Male  5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Vesta Holcomb,

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased November 10th. 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-14-  
1942 to 9-24-1942,  
that I last saw him alive on 9-24-42  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	65	9	14	hr. min.

Immediate cause of death Pulmonary embolism

Duration 3 hrs

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

Due to Gangrene of gallbladder 3 wks

10. Usual occupation Carpenter,

Due to operation for " 1 wk.

11. Industry or business Contractor,

Other conditions (Include pregnancy within 3 months of death) 127 lb!

12. Name Lyman Holcomb,

Major findings: Of operations Gangrenous gallbladder

Of autopsy \_\_\_\_\_

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

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

14. Maiden name Cassie Wilson,

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

16. (a) Informant Mrs John W. Holcomb

(b) Address Amazonia, Missouri,

17. (a) Burial (b) Date thereof 9/26/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah, Mo. Cem.

18. (a) Signature of funeral director M. H. Bauman

(b) Address 319 So. 10th. Street, Hannibal

19. (a) 9-26-42 (b) Rose Herges  
(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 Paul Ferguson (M. D. or other)

Address St. Joseph, Mo. Date signed 9-28-42

AUG 23 1945

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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 Sept. 24, 1945

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Wm. E. Summersfield

Licensed Embalmer No. 3007

P. O. Address 319 So. 10 St Joseph 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.