

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 447

FILED FEB 10 1943
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution NO.
(Specify whether)

In this community all his life
years, months or days

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

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

(d) Street No. 917 North Monroe,
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Cecil Francis Holman

3. (b) If veteran, name war NO. 3. (c) Social Security No. none

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

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

7. Birth date of deceased May 18 1903
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

39	8	8	hr. min.
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9. Birthplace Washington
(City, town, or county) (State or foreign country)

10. Usual occupation Radio Operator

11. Industry or business x no S. S. #

MOTHER FATHER { 12. Name John C. Holman,

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

14. Maiden name Magdaline LaRoche,
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Magdaline Holman,

(b) Address 917 North Monroe, Kansas City, Mo.

17. (a) Burial Burial (b) Date thereof 1-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 1-28-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 26th
year 1943 hour 4:45 minute P. M.

21. I hereby certify that I attended the deceased from Coroner
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
Duration _____

Due to Chronic emphysema with dilatation of right heart

Due to 1100

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy see above

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 _____ (e) Means of injury _____

23. Signature R. C. No. (M. D. or other) _____

Address _____ Date signed 1/27/43

10-1-1966

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..... *E. M. Plouffe*

Licensed Embalmer No. *1848*

P. O. Address..... *R. C. 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.