

1. PLACE OF DEATH:
(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:
General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-9-42-1-7-43
(Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1611 E. 12
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME CHARLES W. HOLMES
3. (b) If veteran, name war no 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 7
year 1943 hour 4:50 minute a. M.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive years
7. Birth date of deceased February 5 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 9 1942 to January 7 1943
that I last saw him alive on January 7 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>11</u>	<u>2</u>hr.min.

Immediate cause of death Terminal Broncho-pneumonia
Due to Adenocarcinoma of trachea

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

Due to 47 B
Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Janitor
11. Industry or business Business

Major findings: Of operations
Of autopsy Same as above

MOTHER FATHER { 12. Name Charles W. Holmes
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Minerva
15. Birthplace unknown
(City, town, or county) (State or foreign country)

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) (Country) (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 _____

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2
17. (a) Burial (b) Date thereof 1-11-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery
18. (a) Signature of funeral director Shaham Burr
(b) Address 2208 Vine St.
19. (a) 1-16-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

23. Signature G. O. Turner (M. D. or other)
Address Chm. Hoag #2-602 E 22 Date signed 1-8-43

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

48
3
9

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

#0

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 *B. L. Graham*

Licensed Embalmer No. *2540*

P. O. Address *2208 Vinoo*

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.