S. No. 2
0M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 6419

Registration District No. FILED MAR 14 1944

Primary Registration District No. 3000

Registrar's No. 41

**1. PLACE OF DEATH:**

(a) County Adair

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

(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days (Specify whether
In this community 14 days
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Adair

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

(d) Street No. 100 N Wabash St.
(If rural, give location)

(e) Citizen of foreign country? no ~~(Yes or No)~~

If yes, name country

3. (a) PRINT FULL NAME Holden, James

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 29 (Day) 1864 (Year)

8. AGE: Years 79 Months 6 Days 7 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Andrew Holden
13. Birthplace (City, town, or county) Jel (State or foreign country)

MOTHER
14. Maiden name Mary Wilsie
15. Birthplace (City, town, or county) Ky (State or foreign country)

16. (a) Informant Mrs Buck Stout
(b) Address Canton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8-44 (Month) (Day) (Year)
(c) Place: burial or cremation Day

18. (a) Signature of funeral director Otis Gutting
(b) Address Kahoka Mo.

19. (a) 2/8/44 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

1044

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 6th year 1944 hour 8 minute 15a M.

21. I hereby certify that I attended the deceased from 1/23/44, 19 , to 2/6/, 1944 that I last saw him alive on 2/5/, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Embalism (multiple)

Due to Thrombosis in both lower extremities

Due to Sclerotic changes in circulatory system

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 99.1

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? (e) Means of injury 2

23. Signature [signature] ~~(M. D. or other)~~ D.O.

Address Kirksville Date signed 2/6/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-44-514
Date Filed MAR 8 1944

## 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 W. C. Summers

Licensed Embalmer No. 21 59

P. O. Address Kirksville 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.**