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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 29 1945

Registration District No. 449

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 8627

Registrar's No. 1140

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: Research Hospital. 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks (Specify whether

In this community 1 year (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Blue Springs 0 (If outside city or town limits, write "RURAL")

(d) Street No. Evangelical Pastors Home 0 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Rev. E.G. HOLDER.

3. (b) If veteran, name war — no

3. (c) Social Security No. none

4. Sex M D

5. Color or race W

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

6. (b) Name of husband or wife Paula

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Feb. 5. 1874 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	1	6	hr. min.

9. Birthplace Germany 11 (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business Retired Minister.

FATHER
12. Name Unknown
13. Birthplace Germany 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Germany 11 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Paula Holder

(b) Address Blue springs mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Blue springs mo

18. (a) Signature of funeral director Mrs G.B. Wilkinson

(b) Address Blue Springs Mo

19. (a) 3-11-45 (Date received local registrar) (b) T.E. Bloom (VZ) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 11th year 1945 hour 1:58 PM minute M.

21. I hereby certify that I attended the deceased from 1-28-45, 19, to 3-11-45, 19; that I last saw him alive on 3-11-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Empyema c̄ toxic absorption

Due to Pneumonia Bronchial

Due to

Other conditions (Include pregnancy within 3 months of death) 92 b

Major findings:
Of operations Pneumonia
Of autopsy Empyema, Mitral stenosis, Cerebral infarct rt. frontal lobe

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

23. Signature MO (03900) (M.D. or other)

Address 934 Argyl Bldg - KC Date signed 3-11-45

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(Licensed Embalmer's Statement on Reverse Side)

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 R B Wright

Licensed Embalmer No. 2353

P. O. Address Blue springs 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.