S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 26457

FILED AUG 29 1945

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 3315

**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: Little Sister, 5331 Highland 5 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Mo. (Specify whether years, months or days)

In this community 2 Years 8 Months

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")

(d) Street No. 5331 Highland 8 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

**3. (a) PRINT FULL NAME** James Holton

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 4 (Month) 4 (Day) 1869 (Year)

8. AGE: Years 76 Months 4 Days 1 If less than one day hr. min.

9. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Patrick Holton
13. Birthplace No record (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Ann Gorgon
15. Birthplace No record (City, town, or county) 9 (State or foreign country)

16. (a) Informant Little Sisters of Poor

(b) Address 5331 Highland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 7 (Day) 45 (Year)

(c) Place: burial or cremation St Johns, N.C.K.

18. (a) Signature of funeral director Burk + Tobin

(b) Address 20 W. Linwood

19. (a) 8-7-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 8 day 5 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 8-1, 1945 to 8-5, 1945 that I last saw him alive on 8-3, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Coronary thrombosis | 5 days |
| Due to arteriosclerosis | years |
| Due to myocarditis | years |
| Other conditions: (Include pregnancy within 3 months of death) 94a | |

Major findings: Of operations none

Of autopsy none

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 0

23. Signature John T. Skinner (M.D. or other) MD

Address 110 S Grand Ave Date signed 8-6-45

(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 Charles M. Quirk

Licensed Embalmer No. 3774

P. O. Address N. 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.**