

S. No. 2
M-8-43
v. 5-17-39
I X37823

30261

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 282

FILED OCT 7 9 1945

Registration District No. 77 Primary Registration District No. 3008

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

1. PLACE OF DEATH:

(a) County: Callaway

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

(c) Name of hospital or institution:
Callaway Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution: 12 Days
(Specify whether)

In this community: Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Callaway /4

(c) City or town: Guthrie Missouri ?
(If outside city or town limits, write "RURAL")

(d) Street No.: _____
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME: Alvin Edgar Holmes

3. (b) If veteran, name war: No.

3. (c) Social Security No.: No.

4. Sex: Male 5. Color or race: White

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

6. (c) Age of husband or wife if alive: 60 years

7. Birth date of deceased: Nov. 10 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>9</u>	<u>27</u>	hr. _____ min.

9. Birthplace: Callaway County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Blacksmith

11. Industry or business: William Holmes

MOTHER FATHER { 12. Name: _____

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

14. Maiden name: Elizabeth Bybie

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

16. (x) Informant: Alvin W. Holmes

(b) Address: 7335 BARBARIE ST. Jacksonmo Mo

17. (a) Burial (b) Date thereof: 9 9 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Guthrie Cemetary

18. (a) Signature of funeral director: Ray C. Holt

(b) Address: New Bloomfield Mo.

19. (a) 9-9-1945 (b) Joan Morantoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1945 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug 27 1945 to Sept 7 1945
that I last saw him alive on Sept 6 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Subtotal Obstruction & Peritonitis

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Obstruction & Peritonitis

Of autopsy: no

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? _____ (c) Means of injury: 0

23. Signature: E. M. Erickson (M. D. or other) _____

Address: New Bloomfield Mo Date signed: 9-8-45

1147

RECEIVED

District Health Officer No. 9.

District File Number.....

Date Filed 10-8-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m^x or by.....

LeRoy Claypool

374

....., Registered Apprentice No.....

working under my personal supervision.

Signed Ray A. Holt

Licensed Embalmer No. 2603

P. O. Address New Bloomfield 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.