

FILED JAN 21 1946

Registration District No. 194

Primary Registration District No. 3035

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7 11th St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7 - 11th St  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

ROBERT L. HOLMAN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife. Hattie C. Phelps 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased. Oct. 24 1879  
(Month) (Day) (Year)

8. AGE: Years 66 Months 0 Days 11 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name James H. Holman  
13. Birthplace Joplin Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Lucy A. Wheeler  
15. Birthplace Barron Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hattie Holman  
(b) Address Springfield, Mo  
17. (a) Burial (b) Date thereof 11-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Dover, Mo

18. (a) Signature of funeral director James H. Trump  
(b) Address Springfield, Mo  
19. (a) 12 January (b) Thomas E. Caldwell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7  
year 1945 hour 1 minute 30 P. M.  
21. I hereby certify that I attended the deceased from Nov 1 45 to Nov 7 45  
that I last saw him alive on Nov 7 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary & Renal failure  
Due to: Voluntary dissection of heart decussation  
Due to: Acute nephritis

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

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: 928

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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature: [Signature] (M. D. or other) \_\_\_\_\_  
Address: [Address] Date signed 11/8/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
100517

1-15-46

Ed. Paul

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**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

*Ed. Paul*

Licensed Embalmer No.

*2983*

P. O. Address

*Leesington 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.**