

FILED NOV 5 1946

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 4408

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:
Vineyard Park Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
(Specify whether
 In this community 21 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 40
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 1924 west 37th. St. 8
(If rural, give location)
 (e) Citizen of foreign country? no 0
(Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME

John Holmes

3. (b) If veteran, name war no

3. (c) Social Security No. 487-16-5507

4. Sex M

5. Color or race Wh

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb
(Month)

4 1881
(Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 16 hr. min.

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

10. Usual occupation Brass Molder

11. Industry or business

MOTHER FATHER

12. Name John August Fischer

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

14. Maiden name Hannah Peterson

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

16. (a) Informant Lena Whitney (sister)

(b) Address 4012 Kansas

17. (a) Burial (b) Date thereof 10-23-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington

18. (a) Signature of funeral director Gates Funeral Home

(b) Address Kansas City, Kansas

19. (a) 10-21-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20
 year 1946 hour 8 minute 40 P.M.

21. I hereby certify that I attended the deceased from Oct. 18 1946, to Oct 20 1946
 that I last saw him alive on Oct 20 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema 6 days
 Duration

Due to Broncho-pneumonia 10 days

Due to

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy
 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?

While at work? 0
(Specify type of place) (c) Means of injury

23. Signature John Sheldon (M. D. or other)
 Address 2604 S. Locust St. Kansas City, Mo. Date signed 20 Oct 48

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 *D. Ross Blanford*

Licensed Embalmer No. *4015*

P. O. Address. *414 State Line*

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.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4408

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Vineyard Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1924 W. 37th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John A. Holmes

3. (b) If veteran, name was _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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 _____ (M. D. or other) _____

Address _____ Date signed _____

MOTHER FATHER

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Steraldine Holmes
(Designated local registrar) (Registrar's signature)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33599

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

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

3. (a) PRINT
FULL NAME

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
 { 13. Birthplace..... (City, town, or county) (State or foreign country)
 { 14. Maiden name.....
 { 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town..... (If outside city or town limits, write "RURAL")
 (d) Street No..... (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

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

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

Immediate cause of death.....
 Due to.....
 Due to.....
 Other conditions..... (include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations.....
 Of autopsy.....

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?
 While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.