No. 300
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5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 7 1948
Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 16376
Registrar's No. 2218

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

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: 1520 E 8 /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1520 E 8 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Arthur T. Holsburg
3. (b) If veteran, name war None
3. (c) Social Security No. Donot know

4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced S O
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased June 1 1878 (Month) (Day) (Year)

8. AGE: Years 69 | Months 11 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Kansas / (City, town, or county) (State or foreign country)
10. Usual occupation Barber
11. Industry or business Self.

FATHER
12. Name Adam Holsburg /
13. Birthplace Penn (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Calina Taylor /
15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carrie Hay
(b) Address Wellsville KS
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 28 48 (Month) (Day) (Year)
(c) Place: burial or cremation Wellsville KS
18. (a) Signature of funeral director Passantino Bros
(b) Address KCMO
19. (a) 5-27-48 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1948 hour 7 minute 30 P M.

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

	Duration
Immediate cause of death Coronary sclerosis	
Due to Arterio sclerosis	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) 93 d	

Major findings:
Of operations ____
Of autopsy no
History & Impression

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 [signature] (M. D. or other)
Address 1424 Prof. Bldg Date signed ____

(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.....Francis Walter

Licensed Embalmer No.....2744

P. O. Address.....12 Como

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.