

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33554**  
**4538**

FILED NOV 13 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4538

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas Citu.</u> <u>8150</u>	
c. LENGTH OF STAY (in this place) <u>3 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>1510 Walker</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Nurs. Home</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Martha</u>	b. (Middle) <u>M.</u>	c. (Last) <u>Holyfield</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 26 1950</u>
--	--------------------------	-----------------------	----------------------------	---

5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> ✓	8. DATE OF BIRTH <u>May 18, 1872</u>	9. AGE (In years last birthday) <u>78</u>	10. UNDER 1 YEAR Months _____ Days _____	11. OVER 1 YEAR 1 YEAR _____ 2 YEARS _____ 3 YEARS _____ 4 YEARS _____ 5 YEARS _____
------------------	-------------------------------	---	--------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>D. L. Kidd</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE _____
--------------------------------------	--	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Thomas Adams</u>	ADDRESS <u>1510 Walker KC.K</u>
--	-------------------------------------	--	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture neck left femur</u>		<u>10/18/50</u>
	DUE TO (c) <u>Vascular hypertension</u>		<u>unknown</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City, Jackson, Mo.</u>
---	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-18-50</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>fall in Nursing Home</u>
--	---	--

22. I hereby certify that I attended the deceased from 10/20/50 to 10/25/50, that I last saw the deceased alive on 10/25/50, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>C.S. Coffey DO</u> (Degree or title)	23b. ADDRESS <u>Kansas City, Mo.</u>	23c. DATE SIGNED <u>10/27/50</u>
--	--------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>10/28/1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Marwood</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>
--	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>10-28-50</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Fulton</u>	ADDRESS <u>Kansas City, Kans</u>
--	---	---	----------------------------------

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

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Ralph Fulton*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3503

P. O. Address Kan City 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.