

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

43321

State File No.

5510

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>002</u>		Registrar's No. <u>5510</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>1 mon</u>		c. CITY OR TOWN <u>Slater</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Queen of World Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2001 S. 21st St</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sallie</u>		b. (Middle)		c. (Last) <u>Holt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 17 55</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, <u>WIDOW</u> , DIVORCED (Specify)		8. DATE OF BIRTH <u>March 8, 1867</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Calloway Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jim Northcut</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Press Holt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Reuben Holt 231 1/2 Montgall</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute congestive failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis Ht. Disease</u> DUE TO (c) <u>fractured hip</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2000</u> <u>21</u>	
19a. DATE OF OPERATION <u>Nov. 29</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture of left hip.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home Residence</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City Jackson Missouri</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11-21-55</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Patient fell down steps</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 21, 1955</u> , to <u>Dec. 17, 1955</u> , that I last saw the deceased alive on <u>Dec. 17, 1955</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>George H. Taft</u> (Degree or title) ^D				23b. ADDRESS <u>2204 E. 18th Street</u>		23c. DATE SIGNED <u>12-19-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>12 19 55</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-19-55</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter B. ...</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

~~1911~~

Dec 1-4-28
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Bruce P. Watkins*

Licensed Embalmer No. *45*

P. O. Address *18th Street*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.