

Dept. Health,  
c. & Welfare  
S. Public  
alth Service

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

74781  
STATE FILE NUMBER  
6159

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6159

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>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hosp. 65 yrs</u>		Length of stay in lb <u>65 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>416 N. Kensington</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Lertunde</u> Last <u>Holland</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14-1889</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
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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>at home</u>	11. BIRTHPLACE (City and state or country) <u>Shelbina, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jess A. Beeler</u>	13b. MOTHER'S MAIDEN NAME <u>Roberta Lear</u>	14. NAME OF HUSBAND OR WIFE <u>Cyrus H. Holland</u>
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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>488-27-0249</u>	17. INFORMANT <u>Ronald Krampfe</u> Address <u>416 N. Kensington</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstruction (thrombo embolism) of left Pulmonary artery 1/2 hr</u>		INTERNAL BETWEEN ONSET AND DEATH <u>may years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Obesity</u> DUE TO (c) <u>Bronchial asthma</u>		<u>may years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>2417</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>12-24-57</u> to <u>12-25-57</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>12-24-57</u> Death occurred at <u>8:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Robert H. Hodge</u> M.D.	(Degree or title) <u>MD</u>	22b. ADDRESS <u>339 Arman North Kansas City Mo</u>	22c. DATE SIGNED <u>12-27-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-28-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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24. FUNERAL DIRECTOR <u>C.S. Blackman &amp; Son Inc.</u> ADDRESS <u>K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-27-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minchall</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Robert H. Hodge USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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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 *W. C. Quinn* .....

Licensed Embalmer No. *4879* .....

P. O. Address *H. C. Ma* .....

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.