

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044173

STATE FILE NUMBER  
5785

FILED DEC 30 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in lb 138 DAY	d. STREET ADDRESS (If outside, give location) 815 & 1927 Parallel Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last ELDO H. HOLINSWORTH			4. DATE OF DEATH Month Day Year DECEMBER 6, 1958		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-89	9. AGE (In years at birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER WALLACE MFG		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or county) Pleasant Gap, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Woodson Barney Holinsworth		13b. MOTHER'S MAIDEN NAME Lindsey Strickland		14. NAME OF HUSBAND OR WIFE Ellen Marie Holinsworth	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or No, or unknown) Yes 9-19-17 to 4-14-19		16. SOCIAL SECURITY NO. 509-09-8071	17. INFORMANT Address OFFICIAL RECORDS, VA HOSPITAL, K.C. MO.		
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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) Pneumonia				INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bronchial carcinoma			
	DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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.) 11021		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					

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. Attended the deceased from 7-21-58 11:45 PM to 12-6-58 12:55 PM		Death occurred at on the date stated above; and to the best of my knowledge, from the causes stated.			
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22a. SIGNATURE E. Foroughi M.D.		(Degree or title) D	22b. ADDRESS V.A. Hospital, K.C., Mo	22c. DATE SIGNED 12-6-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 12-6-58	23c. NAME OF CEMETERY OR CREMATORY CHAPEL HILL	23d. LOCATION (City, town, or county) (State) KANSAS CITY KANS.
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24. FUNERAL DIRECTOR D.W. Newman Son 1954		ADDRESS	25. DATE RECD. BY LOCAL REG. 12-8-58	26. REGISTRAR'S SIGNATURE New Marshall
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. Foroughi

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 *Thomas W. Johnson* .....

Licensed Embalmer No. *27889* .....

P. O. Address *A. C. Johnson* .....

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.