

No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

24175

State File No. 3231

FILED AUG 13 1947
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

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: Mercy Childrens Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days) 2 mo. 16 days

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 917 E. 15th
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME RANDAL B. Holmes FOOKES

3. (b) If veteran, name war No

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1947 hour Febr minute 45 P.M.

21. I hereby certify that I attended the deceased from 7-29- 1947, to 7-30 1947
that I last saw him alive on 7-30- 1947
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married: single
divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: May 13 1947
(Month) (Day) (Year)

Immediate cause of death Pneumonia, Bronchial

Due to ?

Due to _____

8. AGE: Years Months Days If less than one day

0 2 16 - hr. - min.

9. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation None

Other conditions Enlarged Thymus
(Include pregnancy within 3 months of death)

Major findings: Of operation None

Of autopsy None

PHYSICIAN _____
Underline the cause of which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Vern H. Fookes

13. Birthplace Arkensaw
(City, town, or county) (State or foreign country)

14. Maiden name Kessie Knight

15. Birthplace Arkensaw
(City, town, or county) (State or foreign country)

16. (a) Informant Vern H. Fookes
(b) Address 917-E-15th

17. (a) Burial (b) Date thereof Aug. 1, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Mrs. C. P. Foster
(b) Address K.C., Mo.

19. (a) 8-1-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

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 _____ Means of injury _____

23. Signature D. C. F. Holmes (M. D. or other) M.D.
Address Mercy Hospital Date signed 309/1947

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert A. Herrmann

Licensed Embalmer No. 3700

P. O. Address. K. e. 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.