

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

18580

1. PLACE OF DEATH *Beane* Registration District No. *92*  
 County *Beane* Primary Registration District No. *4041*  
 1. Township *Centralia* (No. *1*) St. *Centralia* Ward *1*  
 City *Centralia* (No. *1*) St. *Centralia* Ward *1*  
 2. FULL NAME *Mary Elizabeth Kirk*  
 (a) Residence. No. *1* St. *Centralia* Ward *1*  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*  
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *J.H. Kirk*  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 16 - 1866*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*64 0 16*

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Housewife*  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Illinois*  
 (STATE OR COUNTRY)

10. NAME OF FATHER *Mr. Van Cleave*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *New Jersey*  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER *Frank Callaway*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Illinois*  
 (STATE OR COUNTRY)

14. INFORMANT *R.V. Kirk*  
 (Address) *Slater Mo.*

15. FILED *6/3 1930* *J. I. Kirkson*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 1st 1930*  
 17. I HEREBY CERTIFY, That I attended deceased *from 1st to 30th*  
~~of~~ *June 1st to 30th* 1930, to *Centralia, Mo.*  
 that I last saw *her* alive on *May 24th* 1930, and that death occurred, on the date stated above *at Centralia, Mo.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Myocardial infarction*  
*uncomplicated*  
 (duration) yrs. *4* mos. ds.

CONTRIBUTOR (SECONDARY) *MA*  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF  
 WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) *W. J. Hayes* M. D.

*June 3, 1930* (Address) *Centralia, Mo.*  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
*Centralia Mo* *June 3 1930*

20. UNDERTAKER ADDRESS  
*N. McDonald* *Centralia Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

*21 1930*  
*16*  
*2*

1820