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

Do not use this space.

File No. 38741

Registered No.

1. PLACE OF DEATH

County: Saline

Township: Grand Rock

Registration District No. 79N

Primary Registration District No. 6035

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Clarence Franklin Kirby

(a) Residence. No. ..... St., ... Ward. .....
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Sylvine Kirby

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 10th 1874

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	59	5	26	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Wis

PARENTS

10. NAME OF FATHER: Clarence Kirby

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo

12. MAIDEN NAME OF MOTHER: Elizabeth Burch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): England

14. INFORMANT: Mrs Sylvine Kirby
(Address): Nelson Mo.

15. FILED 11-8, 1933 C. L. Lawless
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 6 1933

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1933 to Nov 6, 1933 and that that I last saw him alive on Nov 6, 1933 and that death occurred, on the date stated above, at 5:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis

about two hours

duration ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ✓

..... (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) R. W. Stoughton, M. D.

11-6, 1933 (Address) Nelson 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
Ridge Park Cem	Nov 8 1933
20. UNDERTAKER	**ADDRESS**
P W Campbell	Marshall

ITEM PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.