

JUN 17 1940

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

18573
Do not use this space.

1. PLACE OF DEATH

(a) County Howard
(b) Township Burton
(c) City R. F. D. Higbee
(e) Length of residence in city or town where death occurred 610 yrs. mos. ds.

2 Registration District No. 378
Primary Registration District No. 5528

Registered No. 84

(d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

M. B. Kirby
(a) Residence, No. R. F. D. Higbee St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
Mary Ann Kirby

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 6 1868

7. AGE YEARS 72 MONTHS 3 DAYS 12
If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co. Mo.

13. NAME Joseph Kirby

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co. Mo.

15. MAIDEN NAME Martha Francis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard Co. Mo.

17. INFORMANT Mrs. B. M. Kirby
(ADDRESS) R. F. D. Higbee Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE City Cem. Higbee May 21 40

19. FUNERAL DIRECTOR Joe W. Burton
(ADDRESS) Higbee Mo.

20. FILED James S. Bonham 1940
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 8, 1940, 19____, to May 18, 1940, 19____.

I last saw him alive on May 8, 1940, 19____. Death is said to have occurred on the date stated above, at 8 a. m.

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Attacks
off and
on for
the past
3 mos.

Other contributory causes of importance:

Name of operation none Date of # _____
What test confirmed diagnosis Clinical. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify # _____

(Signed) W. D. Higbee
(Address) Higbee, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
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

1 X12004

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-13-70

STATEMENT BY LICENSED EMBALMER

I, Ornel Robinson, Licensed Embalmer No. 4101

hereby certify that the body recorded on the reverse side of this certificate was embalmed by MJE

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Ornel Robinson
Licensed Embalmer No. 4101

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **185-73**

Registration District No. **378**

Primary Registration District No. **55-28**

Registrar's No. **34**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
HOWENA MOORE

1. PLACE OF DEATH:
 (a) County Howard
 (b) City Boonville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)
 In this community.....

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Marion Bruce Kirby
3. (b) If veteran, name war.....
3. (c) Social Security No......

4. DATE OF DEATH: Month 5 day 18
 year 1946 hour..... minute..... M.
MEDICAL CERTIFICATION

4. Sex m **5. Color or race** W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... **6. (c) Age of husband, or wife, if alive**..... year.....
7. Birth date of deceased (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
 that I last saw him alive on....., 19.....,
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

8. AGE: Years 72 Months 3 Days 12 If less than one day, hr..... min.....

22. If death was due to external causes, fill in the following:
 Due to.....
 Due to.....

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

Other conditions..... (Include pregnancy within 3 months of death)

10. Usual occupation.....

Major findings:
 Of operations.....
 Of autopsy.....

11. Industry or business.....
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name..... (City, town, or county) (State or foreign country)
15. Birthplace..... (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant.....
(b) Address.....

(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?.....

17. (a)..... **(b) Date thereof**..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

While at work?..... **(e) Means of injury**.....

18. (a) Signature of funeral director.....
(b) Address.....

23. Signature W. V. Dundero D. () other.....
 Address Highway 500 Date signed.....

19. (a) June 5 **(b)** W. V. Dundero
(Date received local registrar) (Registrar's signature)

SUPPLEMENTAL

