

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. **236**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(c) Name of hospital or institution **State Hospital #1 Fulton**
(d) Length of stay: In hospital or institution **1st. 1st. 3**
In this community **4 years.**

3. (a) PRINT FULL NAME **Mary Katherine Kirk**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **72**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **WIDOWED**

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

7. Birth date of deceased **MARCH 3, 1860**

8. AGE: Years **80** Months **6** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **Chillicothe MO**

10. Usual occupation **Housewife**

11. Industry or business **None**

12. Name **Patrick Charles Carroll**

13. Birthplace **DK. IRELAND**

14. Maiden name **MARYETT & KENNY**

15. Birthplace **DK. IRELAND.**

16. (a) Informant **State Hosp. #1**

(b) Address **Fulton, MO.**

17. (a) (b) Date thereof **4-19-1940**

(c) Place: burial or cremation **Robbery**

18. (a) Signature of funeral director **Mahan and Son**

(b) Address **Robbery, Mo.**

19. (a) **Sept. 17, 1940** (b) **R. M. Craven**

(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **Randolph**
(c) City or town **ROBERLY**
(d) Street No. **614 West End Place.**
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **16** year **1940** hour **5** minute **30 A.** M.

21. I hereby certify that I attended the deceased from **Feb. 1939** to **Sept 16, 1940** that I last saw her alive on **Sept 16, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** Duration **indif.**

Due to _____
Due to _____

Other conditions **Smal. c. pericarditis**
Arteriosclerosis

Major findings: _____
Of operations _____
Of autopsy _____

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

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? **NO** (Specify type of place) _____

23. Signature **Lang E. Moore** (M. D. _____)

Address **Fulton, Mo.** Date signed **9-16-40**

WRITE PLAINLY—USE 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.....

Frank D. Witt

Licensed Embalmer No. *3021*

P. O. Address *Moberly*

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.