No. 2
1-10-39
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X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37695

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4293

FILED DEC 1

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: 3435 Benton (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 40 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo (If outside city or town limits write "RURAL")
(d) Street No. 3435 Benton (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Harry Milton Kirker
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Aug (Month) 5 (Day) 1870 (Year)
8. AGE: Years 70 Months 3 Days 5 If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) Mo (State or foreign country)
10. Usual occupation Invalid for life
11. Industry or business
FATHER 12. Name Ira R Kirker
13. Birthplace ____ (City, town, or county) Pa (State or foreign country)
MOTHER 14. Maiden name Hattie R. Reynolds
15. Birthplace ____ (City, town, or county) Pa (State or foreign country)
16. (a) Informant F. J. Kirker
(b) Address 3435 Benton
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington
18. (a) Signature of funeral director Mrs. C. L. Foster
(b) Address 918 Brooklyn K.C. Mo
19. (a) 11-11-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10 year 1940 hour 9 minute 20 a M.
21. I hereby certify that I attended the deceased from Nov 5, 1940 to ____, 19__, that I last saw him alive on Nov 5, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis	
Due to 93 D	
Due to	
Other conditions Encephalitis (Include pregnancy within 3 months of death)	

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? (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? (e) Means of injury
23. Signature Dean G. Williams (M. D. or other)
Address 806 Prof Bldg Date signed 11/10/40.

(Licensed Embalmer's Statement on Reverse Side)

Prof Eng 12 noon

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address 19 C no

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.