

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
JAN 23 1941

44089
State File No. _____
Registrar's No. _____

Registration District No. 834 Primary Registration District No. 6103

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Rural, Bell City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 years (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME: Arthur Garfield Kirtley
3. (b) If veteran, name war: none
3. (c) Social Security No.: none

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Maudie Pearl Kirtley
6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: Oct. 3 1882
(Month) (Day) (Year)

8. AGE: Years 58 Months 2 Days 22
If less than one day hr. _____ min. _____

9. Birthplace: Center Ridge Arkansas
(City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: _____
12. Name: Unknown
13. Birthplace: _____
(City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: _____
(City, town, or county) (State or foreign country)

16. (a) Informant: Maudie Pearl Kirtley
(b) Address: Bell City, Missouri
17. (a) Burial-Removal: Grandview Cem. Center Ridge, Arkansas
(Burial, cremation, or removal) (b) Date thereof: Dec. 27, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation: _____
18. (a) Signature of funeral director: Howelsh
(b) Address: Sikeston, Mo.
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Stoddard
(c) City or town: Rural--Bell City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No.: Rt 1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 25
year 1940 hour 2 minute 45 P.M.
21. I hereby certify that I attended the deceased from 4-8-1940 to 12-25-1940
that I last saw him alive on 12-25-1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebrovascular disease
Due to: _____
Due to: _____
Other conditions: Chronic Bronchitis
(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): None
(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? _____
While at work? _____ (Specify type of place)
(e) Means of injury: _____
23. Signature: W. Anderson (M. D. or other) _____
Address: Sikeston Date signed: 12-26-40

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

MOTHER FATHER

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.....

.....
Licensed Embalmer No.....

3704

P. O. Address.....

Sixton, Mo.

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44089

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 834

Primary Registration District No. 6103

Registrar's No. _____

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town New Lisbon T.P.
(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

In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Arthur Garfield Kirtley

(b) If veteran, name war _____

3. (c) Social Security No. _____

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 _____ years

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>2</u>	<u>22</u>	hr. min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/20/41 (b) D.S. McFee (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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 W. G. Anderson M.D. or other) _____

Address Union Mo. Date signed _____

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

SUPPLEMENTAL COPY

