

No. 2
4-12-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12191

State File No. _____

Registration District No. 799

Primary Registration District No. 4479

Registrar's No. 22

1. PLACE OF DEATH: **Saline**
 (a) County **Slater**
 (b) City or town _____
 (c) Name of hospital or institution: **none**
 (If outside city or town limits, write "RURAL" and name of township)
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution all his life
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Saline**
 (c) City or town **Slater**
 (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.? D. years.

3. (a) PRINT FULL NAME **Rial Kirtley**
 (b) If veteran, name war **no**
 (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH, Month **March** day **25th**
 year **1941** hour **6** minute _____ P. M.

4. Sex **male**
 5. Color or race **negro**
 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if _____
 alive _____ years
 7. Birth date of deceased **Sept. 28th 1868**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March - 29 - 1941 to March - 25 - 1941
 that I last saw him alive on March - 20 - 1941
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	72	5	27	_____ hr. _____ min.

Immediate cause of death
Cerebral Apoplexy
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings:
 Of operations _____
 Of autopsy _____

Duration

9. Birthplace **Saline County Mo.**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **laborer**

11. Industry or business _____
 12. Name **Rial Kirtley**
 13. Birthplace **don't know**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Maria Craig**
 15. Birthplace **don't know**
 (City, town, or county) (State or foreign country)

PHYSICIAN

 Underline the cause to which death should be charged statistically.

16. (a) Informant **Louella Kirtley**
 (b) Address **Slater, Mo.**
 17. (a) **burial** (b) Date thereof **3-28-'41**
 (Burial, cremation, or other) (Month) (Day) (Year)
 (c) Place: burial or cremation **Slater, Mo.**
 18. (a) Signature of funeral director **Hill Brothers**
 (b) Address **Slater, Mo.**
 19. (a) **3-27-41** (b) W. M. Tuttle
 (Date received local registrar) (Registrar's signature)

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. C. Higgins (M. D. or other) _____
 Address Slater, Mo. Date signed 3/27/41

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

77
2
1

97
2
1

5

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

4-15-41

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.

3090

working under my personal supervision.

Signed

A. C. Hill

Licensed Embalmer No.

3090

P. O. Address

State, Mo.

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.