

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
4273  
Registrar's No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

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:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether  
In this community 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2812 Jarboe  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MICHAEL F. QUIRK

3. (b) If veteran, name war No 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower

6. (b) Name of husband or wife Elizabeth Quirk 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 29 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 110 17 hr. min.

9. Birthplace Co. Limerick, Ireland 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired (1939)

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Quirk  
13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Curtin  
15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ralph D. Fisher

(b) Address 2812 Jarboe

17. (a) Burial (b) Date thereof 10/7/1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Quirk and Robin Co.

(b) Address 20 West Linwood Blvd.

19. (a) 10-7-43 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th  
year 1943 hour 2:45 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1941 to Oct 4, 1943  
that I last saw him alive on Oct 4, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardiasis 2 years

Due to Prostatic Suppression 1 week

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature John D. Skemmer (M. D. or other) MD  
Address 17402 Bryant Blvd Date signed 10-6-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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.....

*Harold Lee*

Licensed Embalmer No. *2810*

P. O. Address *H. C. Lee*

**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.**