

FILED FEB 9, 1944

Primary Registration District No. 5562

Registrar's No. 11

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

**1. PLACE OF DEATH:**

(a) County Iron

(b) City or town Arcadia  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: The Home for aged Baptists  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs - 6 mos 2 days  
(Specify whether years, months or days)

In this community 2 yrs - 6 mos 2 days

3. (a) PRINT FULL NAME William H. Kirk

8. (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 Widowed

6. (b) Name of husband or wife Sarah Elizabeth Moore

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased March 13, 1856  
(Month) (Day) (Year)

8. AGE: Years 87 Months 9 Days 19 If less than one day hr. min.

9. Birthplace Ontario Canada  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

12. Name William Kirk

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

14. Maiden name Mary Ann Shepherd

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

16. (a) Informant Jas H. Bursley

(b) Address Dronton, Mo.

17. (a) burial (b) Date thereof 1-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia Mo

18. (a) Signature of funeral director Wm White & Son

(b) Address Dronton Mo

19. (a) 1-3-44 (b) Francis B. Howard  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Iron

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. The Home for aged Baptists  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 1 year 1944 hour 9:50 minute A M.

21. I hereby certify that I attended the deceased from Dec. 27 1943, to Dec. 27 1943, that I last saw him alive on Dec. 27 1943, and that death occurred on the date and hour stated above.

Immediate cause of death acute bilateral bronchial pneumonia Duration 12/27/43

Due to influenza 12/10/43

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

Other conditions Senility ?  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy ZZA

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. E. Harland (M. D. or other) my self

Address Dronton, Mo Date signed 1/3/44

RECEIVED

District Health Officer No. 4  
District File Number 244-334  
Date Filed 2-7-44

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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.....

was not embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed Amely White.....  
Licensed Embalmer No. 3012.....  
P. O. Address Boston Mass.....

**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, above space should be left blank.**