

FILED JUN 8 1944

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 2025

Registrar's No. 52

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Hogan Hospital 10 Days  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 10 days  
years, months or days

3. (a) PRINT FULL NAME Verner H. Kirkendall

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gertie Kirkendall 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased April 8  
(Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James Kirkendall  
13. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Clara Halley  
15. Birthplace Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Gertie Kirkendall

(b) Address Birch Tree, Mo

17. (a) Burial (b) Date thereof 57 5 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Forrest Cem,

18. (a) Signature of funeral director [Signature]

(b) Address Mountain view, Mo

19. (a) 5710-44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd  
year 1944 hour 9 minute \_\_\_\_\_ p. M.

21. I hereby certify that I attended the deceased from April 23 1944 to May 2 1944  
that I last saw him alive on May 2 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration \_\_\_\_\_

Due to Chronic Pyelitis

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

Other conditions (Include pregnancy within 3 months of death) 133a

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? \_\_\_\_\_

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

23. Signature [Signature] (M.D. or other) \_\_\_\_\_  
Address West Plains, Mo

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

RECEIVED

District Health Officer No. 5,

District File Number 644352

Date Filed 6. 7. 44

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.

NOV 18 1944

Signed John J. Arman  
Licensed Embalmer No. 2516  
P. O. Address Matthews 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.