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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27710

FILED SEP 13 1944

Registration District No. 120

Primary Registration District No. 5450

State File No.

Registrar's No. 95

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

1. PLACE OF DEATH:

(a) County Sentry

(b) City or town Rural Miller Twp
(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 John C. Ireland

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

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced, single

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

7. Birth date of deceased March (unk) 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 5 - hr. min.

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

10. Usual occupation Fisherman

11. Industry or business

MOTHER FATHER

12. Name Thomas Ireland

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

14. Maiden name Margaret Ireland

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

16. (a) Informant Irene Ireland

(b) Address Albany Mo.

17. (a) Burial (b) Date thereof 8/31/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wardview

18. (a) Signature of funeral director Walter W. Baker

(b) Address Albany Mo.

19. (a) Sept 6-1944 (b) Thomas W. Webster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sentry

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1944 hour 11:30 PM M.

21. I hereby certify that I attended the deceased from deceased body after death to in that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Drowning.

Due to 18313

Due to 36

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) accident

(b) Date of occurrence Aug 25 1944

(c) Where did injury occur So. Mill Mo, Grandview
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? (Specify type of place) (e) Means of injury.

23. Signature Dr. J. K. Barnes (M.D. or other)

Address King City Mo Date signed 8/31/44

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3329

P. O. Address Albany, Ill

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.