DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

9998

State File No.

FILED APR 16 1945

Registration District No. 16

Primary Registration District No. 5597

Registrar's No. 25

1. PLACE OF DEATH:
(a) County: Johnson
(b) City or town: Centerview, Mo Route #2
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Centerview
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Johnson
(c) City or town: Centerview, Mo Route #2
(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 ____

3. (a) PRINT FULL NAME: Ace G. Irvin

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: ____

6. (b) Name of husband or wife: Celia Irvin

6. (c) Age of husband or wife if alive: 63 years

7. Birth date of deceased: Feb (Month) 11 (Day) 1863 (Year)

8. AGE: Years 82 | Months — | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: Don't Know (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: Retired salesman

11. Industry or business ____

FATHER
12. Name: William M. Irvin
13. Birthplace: Carroll County (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Sarah Wilson
15. Birthplace: Mendon (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: O. E. Irvin
(b) Address: Centerview, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 3 - 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Centerview Mo

18. (a) Signature of funeral director: H. L. Wilson
(b) Address: Warrensburg, Mo

19. (a) Mar. 2, 1945 (Date received local registrar) (b) Leola M. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1 year 1945 hour 9.30 minute A. M.

21. I hereby certify that I attended the deceased from Jan - 45, 19__, to March 1 - 45, 19__, that I last saw him alive on Feb - 20 - 45, 19__; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Cr. Myocarditis | 2 |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations: 938
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature: R. T. McKinney (M. D. or other)
Address: Warrensburg, Mo Date signed: 3-2-45

1001

(Licensed Embalmer's Statement on Reverse Side)

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

## 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 Myself

....., Registered Apprentice No.....

working under my personal supervision.

Signed Samuel G McClurney

Licensed Embalmer No. 3557

P. O. Address Warrensburg 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.**

No. 2B
1—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 164 Primary Registration District No. 5597 Registrar's No. 25

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Rural Centerview
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jump
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ace G Irwin
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Celia Irwin
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Feb 11 1861 (Month) (Day) (Year)
8. AGE: Years 82 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Ill (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Leola M. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

9998