

FILED OCT 17 1945

Registration District No. _____

Primary Registration District No. 4154

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Greenfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: South Allison St. 1
(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 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade
(c) City or town Greenfield
(If outside city or town limits, write "RURAL")
(d) Street South Allison St. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME

Frank Chatman Kirby

3. (b) If veteran, name was World War I
3. (c) Social Security No. None

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

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

7. Birth date of deceased July 12, 1892
(Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Joseph B. Kirby

13. Birthplace Dade County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Juliet A. Patton

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

16. (a) Informant Mrs. Florence A. House

(b) Address South Greenfield, Mo.

17. (a) Burial (b) Date there Oct 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dadeville Cemetery

18. (a) Signature of funeral director W. L. ...

(b) Address Salina, Mo.
(c) Date received local registrar Oct 1-45 (d) Geo. R. Weir (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30
year 1945 hour 9:50 minute P. M.

21. I hereby certify that I attended the deceased from Sept 1 1945 to Sept 30 1945
that I last saw him alive on Sept 25 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Syphilis - Syphilitic Aneur.

Duration

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 309
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) (d) Means of injury _____

23. Signature D. O. Cowan (M. D. or other)
Address Greenfield Mo. Date signed 10-1-45

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

29
1
0

1420

RECEIVED

District Health Officer No. 6,
District File Number 1048-1825-
Date Filed OCT 15 1945

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.

OCT 22 1945

Signed *William B. Erwin*

Licensed Embalmer No. 3092

P. O. Address *Baltimore, Md*

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.