

**FILED DEC 15 1945** STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 195

19  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage

(c) Name of hospital or institution: P.R.# 4 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months (Specify whether  
+ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. P.R.# 4  
(If rural, give location)

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

3. (a) PRINT FULL NAME William S. Kirby

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

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

6. (b) Name of husband or wife Mikkie Kirby 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 9 - 21 - 1871  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>1</u>	<u>16</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name W. Kirby

13. Birthplace Putnam Co. Mo. ( )  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Kirby

15. Birthplace Putnam Co. Mo. ( )  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mollie Kirby  
(b) Address Carthage Mo.

17. (a) Burial (b) Date thereof 11-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Summitt

18. (a) Signature of funeral director Norma Roman Miller  
(b) Address Miller Mo.

19. (a) 11-7-45 (b) L. B. Clinton M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 7  
year 1945 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Oct. 13, 1945 to Nov. 7, 1945  
that I last saw him alive on Nov. 6, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction  
Due to Broken Compensation 30 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 730  
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) \_\_\_\_\_  
(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) \_\_\_\_\_  
(Specify means of injury)

23. Signature R. A. Hepster M.D. M.D. or other \_\_\_\_\_  
Address Carthage Mo. Date signed Nov. 7

45-11-955

JUN 27 1956

FEB 23 1946

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.

Signed L. R. Lemon  
Licensed Embalmer No. 3297  
P. O. Address Miller 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.