

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29984

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>131</u>		PRIMARY REG. DIST. NO. <u>5469</u>		Registrar's No. <u>15</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>GRUNDY</u>		a. STATE <u>MO</u>		b. COUNTY <u>GRUNDY</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>RU</u>	
b. CITY OR TOWN <u>RURAL FRANKLIN TOWNSHIP</u>		c. CITY OR TOWN <u>RURAL</u>		d. STREET ADDRESS <u>FRANKLIN TOWNSHIP</u>		e. (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		3. NAME OF DECEASED		4. DATE OF DEATH		5. (Month) (Day) (Year)	
		a. (First) <u>JAMES</u>		b. (Middle) <u>ANSEL</u>		c. (Last) <u>KIRK</u>	
		6. DATE OF BIRTH		7. AGE (In years last birthday)		8. IF UNDER 1 YEAR	
		<u>NOV-29-1874</u>		<u>74</u>		<u>10</u> <u>7</u>	
		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
		<u>74</u>		<u>10</u>		<u>7</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAW MILL</u>		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>ROBERT M. KIRK</u>		13b. MOTHER'S MAIDEN NAME <u>ROXIE COON</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>CHIFF KIRK SPICKARD</u> ADDRESS <u>MO.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Organic Heart Disease</u>				<u>2 yrs</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <u>apoplexy</u>				<u>4343</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>47</u> , to <u>Sept</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>49</u> , and that death occurred at <u>11:20 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E W Ewing md</u> (Degree or title)				23b. ADDRESS <u>Spickard Mo</u>		23c. DATE SIGNED <u>9-28-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>SEPT-24-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>COON CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>MERCER CO. MO.</u>	
DATE REC'D BY LOCAL REG. <u>9/26/49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nathan Cooper</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Schooler funeral Home Spickard Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Ross Wise

Licensed Embalmer No. 3771

P. O. Address. Spickard 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.