

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30297

State File No.

FILED AUG 23 1952

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 546 Registrar's No. 2150

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3337 Rex</u>		d. STREET ADDRESS (If rural, give location) <u>3337 Rex</u>	

3. NAME OF DECEASED (Type or Print) <u>Margaret Elizabeth Kirby</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 13 1952</u>		
a. (First)	b. (Middle)	c. (Last)			

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 17 1945</u>	9. AGE (In years last birthday) <u>7</u>	10. UNDER 1 YEAR <u>0</u> Months <u>24</u> Days	11. UNDER 12 HRS. <u>0</u> Hours <u>24</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>Montclair New Jersey</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Michael J Kirby</u>	13b. MOTHER'S MAIDEN NAME <u>Violet Ferguson</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Violet Kirby</u>	ADDRESS <u>3337 Rex Overland Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Falio carcinoma of maxillary sinus</u>		
	ANTECEDENT CAUSES* Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Retard blastoma</u> DUE TO (c) <u>192X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Jan 1945, to 8/13, 1952, that I last saw the deceased alive on 8/13, 1952, and that death occurred at 5:20 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>Walter C. Gray, M.D.</u> (Degree or title)	23b. ADDRESS <u>8938 St. Charles Road St. Louis 14 Mo</u>	23c. DATE SIGNED <u>8/13/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug 15 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Laural Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Little Falls New Jersey</u>
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DATE REC'D BY LOCAL REG. <u>8-14-52</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Douke, MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ortmann F Home</u>	ADDRESS <u>9222 Lackland Overland Mo</u>
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WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Al C Ostmann*

Signed
Student Embalmer

Licensed Embalmer No. *3478*

P. O. Address _____

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.