

FILED SEP 12 1953
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RN 4921

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27880**
Registrar's No. **367**

BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

1. PLACE OF DEATH
a. COUNTY **Butler**

2. USUAL RESIDENCE (Where deceased lived... If institution: residence before admission)
a. STATE **Missouri**
b. COUNTY **Howell**

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Poplar Bluff, Missouri**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **West Plains** **0460**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Veterans Administration Hospital**

d. STREET ADDRESS (If rural, give location) **Route # 3**

3. NAME OF DECEASED (Type or Print)
a. (First) **ROY**
b. (Middle) **D.**
c. (Last) **KIRK**

4. DATE OF DEATH (Month) (Day) (Year)
August 29, 1953

5. SEX **Male**

6. COLOR OR RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **June 9, 1892**

9. AGE (In years last birthday) **61**
if under 1 year: Months _____ Days _____ Hours _____ Mins _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **WELL DRILLER**

10b. KIND OF BUSINESS OR INDUSTRY **DRILLER**

11. BIRTHPLACE (City and State or Foreign Country) **Ipswich, S. Dakota**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **John Kirk**

13b. MOTHER'S MAIDEN NAME **Georgia Delarm**

14. NAME OF HUSBAND OR WIFE **Martha Kirk**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Yes WWI**

16. SOCIAL SECURITY NO. **UNKNOWN**

17. INFORMANT'S SIGNATURE OR NAME **VA HOSPITAL RECORDS** ADDRESS _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Coronary Occlusion**
ANTECEDENT CAUSES
DUE TO (b) **Coronary Sclerosis**
DUE TO (c) _____
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
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 **4201**

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **August 19, 1953, to August 29, 1953**, and that death occurred at **8:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE **T. S. USSERY, Officer of Day** (Degree or title)

23b. ADDRESS **VA Hospital, Poplar Bluff, Mo.**

23c. DATE SIGNED **8-29-53**

24a. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL**

24b. DATE **8-30-53**

24c. NAME OF CEMETERY OR CREMATORY **West Plains Mo**

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. **8/31/53** REGISTRAR'S SIGNATURE **J. R. Threster**

25. FUNERAL DIRECTOR'S SIGNATURE **Green Cross Fitch, Poplar Bluff, Mo** ADDRESS _____

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

RECEIVED

SEP 8 1953
BUTLER CO. HEALTH CENTER

FILE No. _____

SEP 16 1953

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 Joseph P. Matlock

Licensed Embalmer No. 4824

P. O. Address Galax, Va.

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.