

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26835**
Registrar's No. **799**

No. 300
10-48

FILED **JAN 30 1954**
aug.

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **799**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Arkansas b. COUNTY Fulton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Spromafield		c. LENGTH OF STAY (in this place) 3 Wks	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hosp		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) James Riley Irby			4. DATE OF DEATH Aug. 21-1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Jan 1-1893		9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months 7 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Mercantile		11. BIRTHPLACE (City and State or Foreign Country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Joseph Irby		13b. MOTHER'S MAIDEN NAME Margaret Mullins		14. NAME OF HUSBAND OR WIFE Gertie Irby	
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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) No		16. SOCIAL SECURITY NO. 432-09-5016		17. INFORMANT'S SIGNATURE OR NAME Gertie Irby, Mammoth Springs, Ark	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) PNEUMONIC HEART DISEASE INACTIVE, WITH AORTIC STENOSIS ANTECEDENT CAUSES: (b) ARTEROSCLEROTIC HEART DISEASE. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
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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) m.		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 **8-5-54**, 19____, to **Aug. 21, 1954**, that I last saw the deceased alive on **Aug. 20, 1954** and that death occurred at **3:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Glenn T. Jones, M.D.		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 8/23/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-21-1954		24c. NAME OF CEMETERY OR CREMATORY Riverside Cem		24d. LOCATION (City, town, or county) (State) Mammoth Springs Mo.	
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DATE REC'D BY LOCAL REG. 8-23-54		REGISTRAR'S SIGNATURE Edith Williamson		25. FUNERAL DIRECTOR'S SIGNATURE Gorman Scharpf, Springfield, Mo.		ADDRESS	
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(Licensed Embalmers' Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed L. D. Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield, 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.