

No. 300
10.48

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3596**
Registrar's No. **6**

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 6		
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Scott				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston, Mo		c. LENGTH OF STAY (in this place) 47 Year		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston, Mo		1003		
d. FULL NAME OF HOSPITAL OR INSTITUTION 208 Moore Ave Sikeston				d. STREET ADDRESS (If rural, give location) 208 Moore Ave Sikeston, Mo				
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Polk c. (Last) Kirby			4. DATE OF DEATH (Month) (Day) (Year) 1 17 1955					
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 1/5/70		9. AGE (in years last birthday) 85	# MONTHS 0	# DAYS 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY 0		11. BIRTHPLACE (City and State or Foreign Country) Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME W. E. Kirby			13b. MOTHER'S MAIDEN NAME Sally Crowder		14. NAME OF HUSBAND OR WIFE Nora Mez Kirby			
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. X		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Nora Mez Kirby Sikeston Mo				
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Wernia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive heart disease DUE TO (c) Senility					INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 years.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443 X					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 June 1950 , to 17-Jan, 1955 , that I last saw the deceased alive on 17-Jan, 1955 , and that death occurred at 0.5A pm , from the causes and on the date stated above.								
23a. SIGNATURE H. B. Shroyer MD (Degree or title)				23b. ADDRESS Sikeston, Mo.		23c. DATE SIGNED 22-Jan-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/19/55		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Sikeston Mo		
DATE REC'D BY LOCAL REG. 1-25-55		REGISTRAR'S SIGNATURE Mrs Ella Hunter 429		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albritton Funeral Home Sikeston, Mo				

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

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(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED JAN 31 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 155-19

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 John Allerton

Licensed Embalmer No. 2941

P. O. Address Seaton

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.