

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11327**  
**1825**

FILED MAY 16 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **393** PRIMARY REG. DIST. NO. **1002** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>CLAY</b> <b>5088</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY NORTH</b>	c. LENGTH OF STAY (In this place) <b>60 yrs.</b>	c. CITY OR TOWN <b>KANSAS CITY NORTH</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5114 BARNES</b>		STREET ADDRESS (If rural, give location) <b>5114 BARNES</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>H.</b> c. (Last) <b>KIRK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>APR 22 1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED 1</b>	8. DATE OF BIRTH <b>MAY 14, 1892</b>
9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANING</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>PUEBLO, COLORADO</b>
			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>CHARLES KIRK</b>	13b. MOTHER'S MAIDEN NAME <b>LENA WAGNER</b>	14. NAME OF HUSBAND OR WIFE <b>ALICE F. KIRK</b>
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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) <b>No</b>	16. SOCIAL SECURITY <b>492-14-4778</b>	17. INFORMANT'S SIGNATURE OR NAME <b>JOSEPH F. KIRK</b>	ADDRESS <b>7501 BRIAR, PRAIRIE VILLAGE, KANSAS</b>
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of the lung, Primary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>
	ANTECEDENT CAUSES Morbid 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.		<b>10/24</b>

19a. DATE OF OPERATION <b>Feb 18, 1954</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of the Lung</b>	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)
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 **3-24**, 19**51**, to **April 22**, 19**55**, that I last saw the deceased alive on **April 22**, 19**55**, and that death occurred at **6:45 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert H. Hedge</b> (Degree or title) <b>m.d.</b>	23b. ADDRESS <b>379 Armour, north Kansas City, Mo</b>	23c. DATE SIGNED <b>4-23-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>APRIL 26, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>4-25-55</b>	REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. Newcomer's Sons</b>	ADDRESS <b>Kansas City, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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*Mr. Hodge*

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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.....  
Signature of Student Embalmer

Signed *Robert E. Kinnon*

Licensed Embalmer No. *48*

P. O. Address *R.P.M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.