

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41130
STATE-FILE NUMBER

FILED DEC 12 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 475

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>
c. FULL NAME OF (If NOT inhospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS <u>921 Vermont</u>
3. NAME OF DECEASED (Type or print) <u>LIONESS C. KIRGAN</u>			4. DATE OF DEATH <u>December 2, 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 20, 1882</u>
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Universal Atlas</u>	11. BIRTHPLACE (City and state or country) <u>Monroe County Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>John Thomas Kirgan</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Frances Wilkins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mrs. L. C. Kirgan Hannibal Missouri</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> DUE TO (b) <u>Exhaustion & Age</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Jan 1957</u> to <u>Dec 1-57</u> and last saw her/him alive on <u>Dec 1-1957</u> Death occurred at <u>7:35 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. P. Birney M.D.</u>		22b. ADDRESS <u>Hannibal Mo</u>	
22c. DATE SIGNED <u>12-4-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>12/4/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>	
23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>W. C. Wolf</u>		25. DATE RECD. BY LOCAL REG. <u>12-5-57</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lunde</u>		27. REGISTRAR'S SIGNATURE <u>W. P. Birney</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED DEC 10 1957
MARION CO. HEALTH DEPT.
DATE FILED DEC 10 1957

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 *John S. Spang*

Licensed Embalmer No. 1540

P. O. Address Hannibal Miss.

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.