

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010028
STATE FILE NUMBER

FILED MAR 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 900

300
-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oak Grove</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u>		Length of stay in 1b <u>—</u>	d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>OLLIE</u> Last <u>KIRKLAND</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 10 1929</u>	9. AGE (In years last birthday) <u>28</u>	IF UNDER 1 YEAR Months <u>—</u> Days <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>Auto mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>McCracken Co. Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>George KIRKLAND</u>		13b. MOTHER'S MAIDEN NAME <u>REBA - Conway</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>D.W. Newcomer Sr., N.C. Md.</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>Lobar Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8.983 h</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Apoplexy</u>	
	DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>xxx stuck on head</u>	
20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year <u>02/12/1957</u> a.m. <u>—</u> p.m. <u>—</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN OR LOCATION <u>Oak Grove</u>	COUNTY <u>Jackson</u>	STATE <u>MO</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:30</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.				

21. SIGNATURE (Degree or title) <u>D.W. Newcomer Sr. M.D.</u>	22b. ADDRESS <u>6627 Parket SCW</u>	22c. DATE SIGNED <u>2-18-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>FEB-19-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>—</u>	23d. LOCATION (City, town, or county) (State) <u>LOUISVILLE KENTUCKY</u>

24. FUNERAL DIRECTOR <u>D.W. NEWCOMER & SON'S</u>	ADDRESS <u>KANSAS CITY, MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>2-19-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Geo. C. Kealhofer
 All diseases in Part I must be causally related.



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 *Melvin Barton*

Licensed Embalmer No. *4903*

P. O. Address *KC 7th*

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.